# PEEHIP

**Public Education Employees' Health Insurance Plan**

Administered By:
Blue Cross and Blue Shield of Alabama

Effective October 1, 2006

**PUBLIC EDUCATION EMPLOYEE'S HEALTH INSURANCE PLAN**

P. O. Box 302150
Montgomery, Alabama 36130-2150

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Montgomery, Alabama 36104

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**www.rsa.state.al.us**

**BlueCross BlueShield**
**Of Alabama**
An Independent Licensee of the Blue Cross and Blue Shield Association.

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**www.bcbsal.com/peehip**

**Customer Service: 1 800 327-3994**

Rapid Response Forms Order: 1 800 248-5123

Fraud Hotline: 1 800 824-4391

Baby Yourself: 1 800 222-4379

Preadmission Certification: 1 800 354-7412

**Express Scripts, Inc.:**
**Customer Service: 1 866 243-2124**
Claims Questions: 1 800 451-6245
**www.express-scripts.com**

Curascript Specialty Pharmacy: 1 888 773-7376
**www.curascript.com**

14000
Health Plan
12/06

# WELCOME

As Plan Administrator for the Public Education Employees' Health Insurance Plan (PEEHIP), Blue Cross and Blue Shield of Alabama pledges to you that we will provide the best service we can in the administration of your group health care plan. This booklet summarizes your group's benefits. It also summarizes conditions, limitations, and exclusions to those benefits as well as sections explaining eligibility and defining certain words. Please be sure to read the entire booklet. This booklet is a "summary plan description" or "plan."

Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of **independent** Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

If you have any questions please call our Customer Service at 1-800-327-3994.

For online information about your PEEHIP benefits, go to **www.bcbsal.com/peehip.**

This site contains an interactive page which can be used to e-mail a Blue Cross and Blue Shield of Alabama PEEHIP Customer Service Representative. For online information on all benefits available to you as a PEEHIP member along with the corresponding rates, you may go to **www.rsa.state.al.us**.

This booklet contains a summary in English of your plan rights and benefits. If you have questions about your benefits and need assistance in Spanish please contact Customer Service at 1-800-327-3994. Simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

***Atención por favor - Spanish***
***Este folleto contiene un resumen en inglés de sus beneficios y derechos del plan. Si tiene alguna pregunta acerca de sus beneficios, por favor póngase en contacto con el departamento de Servicio al Cliente llamando al 1-800-292-8868. Solicite simplemente un intérprete de español y se proporcionará uno para que le ayude a entender sus beneficios.***

Group Number 14000

# Notice to Enrollees in a Self-Funded Non-Federal Governmental Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than be provided through a health insurance policy. The Public Education Employees' Health Insurance Board has elected to exempt the **Public Education Employees' Health Insurance Program** from the following requirement:

> Prohibitions against discriminating against individual participants and beneficiaries based on health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

The exemption from this Federal requirement has been in effect for the 2006 Plan Year beginning October 1, 2005 and ending September 30, 2006. The election has been renewed for the 2006-2007 Plan Year and subsequent plan years.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

For more information regarding this notice, please contact the Public Education Employees' Health Insurance Plan at the following address:

> Public Education Employees' Health Insurance Plan
> P. O. Box 302150
> Montgomery, AL 36130-2150

# Creditable Coverage Notice About Your Prescription Drug Coverage and Medicare

This information is about your current prescription drug coverage with PEEHIP and prescription drug coverage under Part D of Medicare for people with Medicare. It also explains where to find more information to help you make decisions about your prescription drug coverage.

- PEEHIP has elected to continue providing prescription drug benefits even when members are eligible for Medicare Part D benefits. However, members cannot enroll in Medicare Part D and continue with PEEHIP prescription drug coverage.

- The prescription drug coverage offered by PEEHIP is expected to pay out as much as the standard Medicare prescription drug coverage and, therefore, the PEEHIP prescription drug coverage is considered "creditable coverage" as defined by Medicare.

- "Low-income" individuals may be eligible for prescription drug subsidies. Therefore, these individuals may be better off applying for a subsidy and Medicare Part D (two separate steps).

- Individuals dropping or losing their PEEHIP coverage must enroll in Medicare Part D within 60 days or they will be subject to a higher premium.

If you do decide to enroll in a Medicare prescription drug plan and drop your PEEHIP prescription drug coverage, be aware that you will lose your PEEHIP drug coverage and will not be able to get this coverage back until you drop the Medicare Part D coverage. Keep in mind that you will not be able to take advantage of coverage under both the PEEHIP prescription drug program and through Medicare Part D.

Because the PEEHIP prescription drug coverage is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later without a late enrollment penalty. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15 and December 31.

Compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. In most cases, PEEHIP will continue to be your best choice to maximize your benefits.

An exception may apply to certain "low-income" individuals who may be eligible for prescription drug subsidies, and thus may be better off applying for a subsidy and Part D (two separate steps). Individuals who have incomes below 150 percent of the Federal Poverty Level and assets of not more than $10,000 per individual or $20,000 per couple (not including homes, cars, household furnishings and possessions) may be eligible for the prescription drug subsidies. The Social Security Administration (SSA) has developed an application form and process to determine eligibility. If you feel you may qualify, go to the SSA Web page at **www.socialsecurity.gov** and click Medicare Outreach. Also, you may call or visit your local SSA office for more details; the national toll-free number is 800-772-1213.

PEEHIP members who drop or lose their coverage with PEEHIP and do not enroll in Medicare prescription drug coverage after their current coverage ends, may pay more to enroll in Medicare Part D later. Individuals having a 60-day or longer break in prescription drug coverage that is at least as good as Medicare's prescription drug coverage will be subject to at least 1% per month premium increase for every month after May 15, 2006, that they did not have prescription drug coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. This higher premium will continue as long as you have Medicare coverage. In addition, you may have to wait until the next November to enroll.

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# SUMMARY OF HEALTH BENEFITS

This table is a summary of benefits and is subject to all other terms and conditions of the Plan:

**To maximize your benefits seek medical services from a Preferred Provider who participates in the BlueCard Preferred Provider Organization (PPO) Program. Please call 1-800-810-BLUE (2583) or access our website at www.bcbsal.com to find out if your provider is a PPO member. When using non-preferred providers you can incur significant out-of-pocket expenses in addition to higher deductibles, copays and coinsurance as the provider may bill you for charges in excess of the Allowed Amount (see Allowed Amount in the Definitions section of this booklet).**

Please be aware that not all providers participating in the BlueCard PPO Program will be recognized by us as approved providers for the type of service or supply being furnished as explained more fully in paragraph 5. of "Benefit Conditions."

| INPATIENT HOSPITAL | | |
|---|---|---|
| **Benefit** | **PPO** | **Non-PPO ***** |
| **Coverage** | 365 days of care during each confinement*; $100 deductible per admission**; covered inpatient expenses paid at 100% of the PPO Allowance | 365 days of care during each confinement*; $100 deductible per admission**; covered inpatient expenses paid at 80% of the Allowed Amount |
| **Preadmission Certification** | Required for all admissions except maternity; emergency admissions require notification within 48 hours of admission; **for precertification call 1-800-354-7412 toll-free** | |
| **Inpatient Rehabilitation** | 60 days of care in a lifetime, $100 deductible per admission, covered inpatient expenses paid at 100% of the PPO Allowance | 60 days of care in a lifetime, $100 deductible per admission, covered expenses paid at 80% of the Allowed Amount |

* If you are discharged from and readmitted to a hospital within 90 days, the days of each stay will apply toward your 365 day maximum; inpatient hospital days are limited to a combined PPO and Non-PPO maximum of 365 days for each confinement.

** The deductible is due for each admission or readmission; however, only one deductible is due per pregnancy, during transfers from one hospital to another, or when two or more family members are admitted as inpatients as a result of injuries received in one accident.

*** Benefits for admissions to Non-Participating Hospitals in Alabama are only available for treatment of an accidental injury.

| OUTPATIENT HOSPITAL FACILITY SERVICES* | | |
|---|---|---|
| **Benefit** | **PPO** | **Non-PPO** |
| **Surgery** | Covered at 100% of the PPO Allowance, subject to the $75 facility copay | Covered at 80% of the Allowed Amount, subject to the calendar year deductible |
| **Medical Emergency and Hemodialysis** | Covered at 100% of the PPO Allowance, subject to the $25 facility copay | Covered at 80% of the Allowed Amount, subject to the calendar year deductible |

| OUTPATIENT HOSPITAL FACILITY SERVICES* - Continued | | |
|---|---|---|
| **Benefit** | **PPO** | **Non-PPO** |
| **Accidental Injury** | Covered at 100% of the PPO Allowance with no deductible or copay required | Covered at 100% of the Allowed Amount with no deductible or copay within 72 hours of the accident; thereafter, covered at 80% of the Allowed Amount, subject to the calendar year deductible |
| **Diagnostic Lab & Pathology** | Covered at 100% of the PPO Allowance, subject to the $3 copay per test (except when performed during outpatient surgery, medical emergency or hemodialysis) | Covered at 80% of the Allowed Amount, subject to the calendar year deductible |
| **Diagnostic X-ray** | Covered at 100% of the PPO Allowance with no deductible or copay required | Covered at 80% of the Allowed Amount, subject to the calendar year deductible |
| **IV Therapy, Chemotherapy and Radiation Therapy** | Covered at 100% of the PPO Allowance, subject to the $25 facility copay | Covered at 80% of the Allowed Amount, subject to the calendar year deductible |
| **Note:** In Alabama, outpatient benefits for non-member hospitals are available **only** in cases of accidental injury | | |

* Benefits will be determined under "OTHER COVERED SERVICES" in the Summary of Health Benefits and Health Benefits sections of this booklet for (1) services in the emergency room if the patient's condition does not meet the definition of a Medical Emergency, and (2) outpatient services not listed in this table.

| HOME HEALTH AND HOSPICE BENEFITS* | | |
|---|---|---|
| **Benefit** | **PPO** | **Non-PPO** |
| **Home Health and Hospice Care Within the State of Alabama** | 100% of the PPO Allowance, no deductible | Not covered |
| **Preferred Home Health and Hospice Care Outside the State of Alabama** | 100% of the PPO Allowance, no deductible; **precertification is required - call 1-800-821-7231** | 80% of the Allowed Amount, subject to the calendar year deductible; the remaining percentage applies toward the annual out-of-pocket maximum; **precertification is required - call 1-800-821-7231** |

* Any covered expenses for Preferred Home Health Care and covered Non-PPO expenses for Preferred Hospice Care apply toward the lifetime maximum.

| PHYSICIAN SERVICES | | |
|---|---|---|
| **Benefit** | **PPO** | **Non-PPO** |
| **Surgery and Anesthesia, In-Hospital Visits, Second Surgical Opinions and Inpatient Consultations** | 100% of the PPO Allowance, no deductible<br><br>TMJ surgical services require precertification | 80% of the Allowed Amount, subject to the calendar year deductible |
| **Diagnostic X-Rays** | 100% of the PPO Allowance, no deductible | 80% of the Allowed Amount, subject to the calendar year deductible |

| PHYSICIAN SERVICES - Continued | | |
|---|---|---|
| **Benefit** | **PPO** | **Non-PPO** |
| **Office Care Services, Emergency Room Services and Outpatient Consultations*** | 100% of the PPO Allowance, subject to the $20 office copay | 80% of the Allowed Amount, subject to the calendar year deductible |
| **Lab Exams**** | 100% of the PPO Allowance, subject to a $3 per service copay | 80% of the Allowed Amount, subject to the calendar year deductible |

* PPO copays are required for each office visit per person and for related office visits of services not requiring copays; PPO copays are not covered expenses.

** The PPO $3 per service copay does not apply when services are provided while the member is a bed patient in a hospital, nor does the PPO $3 per service copay apply for benefits provided under the Enhanced Preventive Care Services.

| ENHANCED PREVENTIVE CARE SERVICES | | |
|---|---|---|
| **Benefit** | **PPO** | **Non-PPO** |
| **Inpatient Visits for Routine Newborn Care** | Covered at 100% of the PPO Allowance with no deductible or copay | Not covered |
| **Well Child Care Exams** | Covered at 100% of the PPO Allowance, subject to the $20 office visit copay; includes six visits during the first year; three visits during the second year; one annual exam for ages 2-6; one exam every two calendar years for ages 7-18 | Not covered |
| **Routine Physical Exams** | Covered at 100% of the PPO Allowance, subject to the $20 office copay; limited to one exam each calendar year for members age 19 or older | Not covered |
| **Routine Immunizations**<br><br>**(Age limitations apply to certain immunizations )** | Covered at 100% of the PPO Allowance with no deductible or copay; the $20 copay will apply to the office visit | Not covered |
| **Routine Pap Smears** | Covered at 100% of the PPO Allowance with no deductible or copay; limited to one per calendar year | Not covered |
| **Routine Mammograms**<br><br>**See Mastectomy and Mammograms (later in this booklet) for additional information** | Covered at 100% of the PPO Allowance with no deductible or copay; limited to one exam for females between the ages of 35-39 and one per calendar year for females age 40 and older; subject to the $20 office visit copay if applicable | Not covered |
| **Routine Prostate Specific Antigen** | Covered at 100% of the PPO Allowance with no deductible or copay; limited to one per calendar year for males age 40 and older; subject to the $20 office visit copay if applicable | Not covered |

| ENHANCED PREVENTIVE CARE SERVICES - Continued | | |
|---|---|---|
| **Benefit** | **PPO** | **Non-PPO** |
| **Other Routine Screening** | Covered at 100% of the PPO Allowance; includes lead screening once by age 2; urinalysis once by age 5, then once between ages 12-17; TB skin testing once before age 1, once between ages 1-4 and once between ages 14-18; CBC or components once per calendar year; cholesterol testing once every five calendar years; hemocult stool check once per calendar year beginning at age 50; sigmoidoscopy once every three calendar years beginning at age 50 | Not covered |

| GENERAL PROVISIONS | |
|---|---|
| | |
| **Calendar Year Deductible** | $100 per person per calendar year; three deductibles per family* |
| **Annual Out-of-Pocket Maximum** | $400 per person (applicable to Other Covered Services) plus the calendar year deductible; covered expenses paid at 100% of the Allowed Amount thereafter for the remainder of the calendar year**; member is responsible for the expenses above the Allowed Amount |
| **Lifetime Maximum** | $1,000,000 lifetime maximum for each covered member; applies only to Other Covered Services, Non-PPO Outpatient Hospital Services, and Non-PPO Physician Services unless otherwise stated*** |

* Only one deductible is required when two or more family members have expenses resulting from injuries received in one accident. When covered charges are paid to meet the deductible for services rendered in October, November, or December, the deductible will not be required the following year. The deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received. Once the maximum number of family members specified above has met the full deductible, no additional covered expenses will be applied toward any family member's individual deductible for the rest of the calendar year; however, all charges applied toward individual deductibles until that point are non-refundable.

** Non-covered expenses, expenses for outpatient Mental Health and Substance Abuse, and the Non-PPO coinsurance on PPO eligible services provided by a Non-PPO provider do not apply toward the Annual Out-of-Pocket Maximum.

*** Expenses for accidental injury rendered within 72 hours of the accident in the outpatient department of a Non-PPO facility do not apply toward the Lifetime Maximum.

| OTHER COVERED SERVICES | |
|---|---|
| **Benefit*** | |
| **Durable Medical Equipment (DME)**** | **Preferred DME Supplier in Alabama:** 80% of the Preferred DME Supplier Fee Schedule, subject to the calendar year deductible<br><br>**Non-Preferred DME Supplier in Alabama:** 80% of the Allowed Amount, subject to the calendar year deductible<br><br>**DME Supplier Outside of Alabama:** 80% of the Allowed Amount as determined by Blue Cross and Blue Shield of that state, subject to the calendar year deductible |

| **OTHER COVERED SERVICES** - Continued | |
|---|---|
| **Benefit*** | |
| **Physical Therapy**** | **Preferred Physical Therapist in Alabama:** 80% of the Preferred Physical Therapist Fee Schedule, subject to the calendar year deductible<br><br>**Non-Preferred Physical Therapist in Alabama:** 80% of the Allowed Amount, subject to the calendar year deductible<br><br>**Physical Therapist Outside of Alabama:** 80% of the Allowed Amount as determined by Blue Cross and Blue Shield of that state, subject to the calendar year deductible |
| **Ambulance Service** | 80% of the Allowed Amount, subject to the calendar year deductible |
| **Chiropractic Services** | **Participating Chiropractors in Alabama:** 80% of the Chiropractic Fee Schedule, not subject to the deductible; after 12 visits in a calendar year, services are subject to precertification<br><br>**PPO Chiropractors Outside Alabama:** 80% of the Allowed Amount, not subject to the deductible<br><br>**Non-Participating Chiropractors in Alabama:** 80% of the Chiropractic Fee Schedule, subject to the deductible<br><br>**Non-PPO Chiropractors Outside Alabama:** 80% of the Allowed Amount, subject to the deductible |
| **Occupational Therapy Services for the Hand and/or Treatment of Lymphedema**** | **Preferred Occupational Therapist in Alabama:** 80% of the Preferred Occupational Therapist Fee Schedule, subject to the calendar year deductible<br><br>**Non-Preferred Occupational Therapist in Alabama:** 80% of the Allowed Amount, subject to the calendar year deductible<br><br>**Occupational Therapist Outside of Alabama:** 80% of the Allowed Amount as determined by Blue Cross and Blue Shield of that state, subject to the calendar year deductible |
| **Allergy Testing and Treatment** | 80% of the Allowed Amount, subject to the calendar year deductible |
| **TMJ** | 80% of the Allowed Amount, subject to the calendar year deductible; non-surgical benefits are limited to a $1,000 lifetime maximum payment<br><br>Surgical care must be precertified at least three weeks prior to surgery |
| **Speech Therapy** | 80% of the Allowed Amount, subject to the calendar year deductible; limited to 30 sessions each calendar year |

* See Other Covered Services in the Health Benefits section for additional services. Most Other Covered Services are paid at 80% of the Allowed Amount after the calendar year deductible is met.

** When using a Preferred or Participating Provider, the provider will bill Blue Cross and Blue Cross will pay him or her directly. If you see a Non-Preferred or Non-Participating Provider, you may have to file your claim and you will be responsible for charges in excess of the Allowed Amount.

| BABY YOURSELF PROGRAM | |
|---|---|
| **Benefit** | |
| **Baby Yourself** | A prenatal wellness program with high-risk pregnancy early intervention; please call Baby Yourself to see if you are eligible to participate at 1-800-222-4379 or 205-733-7065 in Birmingham; eligible participants receive useful gifts that educate and support healthy habits |

| INDIVIDUAL CASE MANAGEMENT | |
|---|---|
| **Benefit** | |
| **Individual Case Management** | Services available through Comprehensive Managed Care; see the Individual Case Management section for details |

| SUPPLEMENTAL ACCIDENT BENEFITS | |
|---|---|
| **Benefit** | |
| **Supplemental Accident Benefits*** | $500 maximum per occurrence for services rendered within 90 days of accidental injury, then payable in Other Covered Services, subject to the calendar year deductible |

* The Allowed Amount for services rendered by a Non-PPO Physician in Alabama is the PPO Allowance.

| INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE** | | | |
|---|---|---|---|
| **Benefit** | **Maximum Benefit Amounts** | **Deductible** | **Copay** |
| **Inpatient PPO Hospital** | 30 days each plan year (10/01-9/30); inpatient substance abuse treatment is limited to one admission each plan year and two admissions in a lifetime | No deductible | No copay days 1-9<br>$15 copay days 10-14<br>$20 copay days 15-19<br>$25 copay days 20-24<br>$30 copay days 25-30 |
| **Inpatient Non-PPO*** | Short-term crisis intervention only | $100 per admission | No copay |
| **Inpatient Physician** | 30 days each plan year (10/01-09/30) | $100 Major Medical deductible | 20% |

* Benefits for Non-PPO Hospitals are available **only** for short-term crisis intervention and **only** until the member is stable enough to be moved to a PPO Hospital.

** For expenses for Mental Health and Substance Abuse, **only** those providers who are part of the Mental Health Preferred Provider Organization are considered PPO. All other providers of care and treatment or expenses for Mental Health or Substance Abuse are considered Non-PPO. Please refer to the section titled Certified Community Mental Health Centers Main Administrative Offices for PPO providers. Outpatient Non-PPO benefits apply to all hospitals and facilities.

| OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE** | | | |
|---|---|---|---|
| **Benefit** | **Maximum Benefit Amounts** | **Deductible** | **Copay** |
| **Outpatient PPO**<br>(applies to Certified Community Mental Health Centers only) | | | |
| **Intake and Evaluation** | Included in the combined 20 visit maximum per member each plan year* | No deductible | $10 per visit |
| **Individual and Family Therapy** | Limited to 2 units per procedure per member each day (billed in 30 minute units)* | No deductible | $10 per procedure |
| **Crisis Intervention** | Limited to 4 units per member each day (billed in 15 minute units)* | No deductible | $10 per day |
| **Psychometric Testing and Diagnostic Testing by technician** | Limited to 5 hours per member each plan year (billed in one hour units) | No deductible | $20 per hour |
| **Psychometric Testing and Diagnostic Testing by computer** | Limited to 1 hour per member each plan year (billed in one hour units) | No deductible | $20 per hour |
| **Group Therapy** | Limited to 2 hours per member each day (billed in 1 hour units)* | No deductible | $5 per hour |
| **Physician Assessment** | Limited to 4 units per member each day (billed in 15 minute units)* | No deductible | $10 per day |
| **Substance Abuse Intensive Outpatient Program** | Limited to 40 visits per member each plan year | No deductible | No copay |
| **Partial Hospitalization** | Limited to 90 visits per member each plan year | No deductible | $20 per day |
| **Adult and Child Mental Illness Intensive Day Treatment** | Limited to 50 visits per member each plan year | No deductible | $10 per day |
| **Adult Rehabilitative Day Program** | Limited to 35 visits per member each plan year | No deductible | $5 per day |
| **Hospital Screening/After Hours** | Limited to $100 per day | No deductible | No copay |
| **Medication Monitoring** | Limited to 2 units per member per day (billed in 15 minute units) | No deductible | No copay |
| **Medication Administration** | | No deductible | No copay |
| **Outpatient Non-PPO** | 10 visits per plan year | $100 Major Medical deductible applies | 50% |

* Limited to a combined 20 visit maximum which includes intake and evaluation, individual, family, and group therapy, crisis intervention, and Physician Assessment.

** For expenses for Mental Health and Substance Abuse, **only** those providers who are part of the Mental Health

Preferred Provider Organization are considered PPO. All other providers of care and treatment or expenses for Mental Health or Substance Abuse are considered Non-PPO. Please refer to the section titled Certified Community Mental Health Centers Main Administrative Offices for PPO providers. Outpatient Non-PPO benefits apply to all hospitals and facilities.

**PRESCRIPTION DRUGS**

**PRESCRIPTION DRUG BENEFITS ARE ADMINISTERED BY Express-Scripts, Inc. (ESI)**

| Benefit | PPO | Non-PPO |
|---|---|---|
| **Drug Card** ***Preferred Rx Products***<br><br>A copay will be charged for each 34-day supply<br><br>Approved maintenance drugs may be purchased up to a 90-day or 100 unit dose supply for refills with one copay when the drug is on the approved list of maintenance drugs and is prescribed as a maintenance drug<br><br>First fill for a new maintenance drug will be a 34-day supply<br><br>Certain medications are subject to Step Therapy<br><br>Pharmacists must dispense generic drugs unless physician indicates in Longhand "Do not substitute" | **Participating Pharmacy:**<br>Each prescription purchased from a Participating Pharmacy will be covered at 100%, subject to the following copays:<br><br>**Generic Drugs:**<br>$5 copay per prescription<br><br>**Preferred Brand Name Drugs:**<br>$30 copay per prescription<br><br>**Non-Preferred Brand Name Drugs:**<br>$50 copay per prescription<br><br>Insulin, insulin needles and syringes purchased on the same day will require only one copay | **Non-Participating Pharmacy in Alabama:**<br>There are no benefits available for prescription drugs purchased from a Non-Participating Pharmacy in Alabama<br><br>**Non-Participating Pharmacy Outside Alabama:** Same as Participating Pharmacy with applicable copays; member will be responsible for the difference between the allowance and drug charge and the copayments |

**NOTE:** To view the most current Preferred Drug List, visit web site **www.express-scripts.com**.

A Participating Pharmacy must dispense a generic medication when one is available. Please read the section titled **HB171 Section 1** for additional information.

Diabetic supplies are included in the Prescription Drug Benefits, except for Medicare eligible members. Please see the section titled **Prescription Drug Benefits** for more information.

Drug benefits for medically necessary fertility drugs are covered at 50% copay for any fertility drug up to a lifetime maximum of $2,500 cost to the PEEHIP plan.

## BeHealthy.com

A healthy lifestyle can mean better health. Blue Cross and Blue Shield of Alabama and PEEHIP offer **BeHealthy.com**, an internet-based health and wellness information service.

Use the Be Healthy web site as your personal resource for health and wellness information. You'll have access to health tools and trackers, the latest news and information about health topics and more – all customized for you.

At **BeHealthy.com,** customizing the site to fit your needs is easy. Just complete a health risk assessment tool, HealthQuotient. The site will then be tailored to fit your personal health needs and provide you with informative health tools based on your assessment.

Taking advantage of all the Be Healthy web site has to offer is easy:

- Got to **www.bcbsal.com**
- Click the "Go to BeHealthy.com" link on the lower right side of the screen
- Log-in to CustomerAccess (You may need to register if you have not already done so)
- Access an array of health resources customized for you

Since the Be Healthy web site is powered by **WebMD**, a respected source of online information, you can rest assured that this is a resource you can depend on for the most up-to-date, comprehensive health information.

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# ELIGIBILITY

## Enrollment Issues

## Open Enrollment

### Current Employees

Open Enrollment for all current employees takes place in July and August for coverage to be effective October 1 of each year. Employees may add new types of coverage, dependent coverage or change coverage types during this Open Enrollment period. **Open Enrollment forms completed on or after September 1 will not be accepted by PEEHIP.** Members can make open enrollment changes online beginning September 1 through September 10. Open enrollment packets are mailed annually to all active and retired members' home address by July 1.
Pre-existing conditions will be waived on all new coverages that are effective October 1.

### New Employees

New employees may enroll on their date of employment, the first day of the month following employment, or October 1 of each year. The *Health Insurance Enrollment Application* must be completed within **30 days of the member's employment date**. If the form is not completed within 30 days, the employee will only be allowed to enroll in single hospital medical coverage effective the date the form is completed.

Waiting periods will apply on pre-existing conditions for all new coverage not effective on October 1 subject to the following conditions. New employees and dependents with effective dates of coverage on or after July 1 through October 1 are given waivers on the waiting periods for pre-existing conditions. Unless proof of previous coverage is received and approved by the PEEHIP office, employees with effective dates of coverage after October 1 but before July 1 will be required to serve a 270-day waiting period on pre-existing conditions.

### Transfers

Employees who transfer from another system are considered **current** employees and must keep existing insurance coverage until the Open Enrollment period for changes to be effective October 1.

## Enrollment Outside of Open Enrollment

### Employees Hired After October 1

New employees hired after October 1 are required to serve a 270-day waiting period on pre-existing conditions unless proof of previous coverage is received and approved by the PEEHIP office. These employees may enroll only on their date of employment or the first day of the month following their date of employment. New employees may add family coverage on their date of employment or within 60 days of employment. **All enrollment forms must be completed within 30 days of member's date of employment or the employee is only eligible to enroll in single Hospital Medical coverage effective the date the form is completed.**

## Loss of Coverage

### Involuntary Loss

Employees whose spouse or other dependent has an involuntary loss of Hospital Medical coverage are allowed to add family coverage to their existing Hospital Medical plan within **60 days** of the loss of coverage. The member must send documentation from the employer in which coverage was lost stating the reason for the loss of coverage. In addition, the letter must provide the employment and termination dates as well as the date insurance coverage ended. Members and/or dependent(s) will be required to serve a 270-day waiting period on pre-existing conditions unless proof of previous coverage is received and approved by the PEEHIP office. If PEEHIP is not notified within **60 days** of the loss of coverage, the member and/or the dependent(s) will be required to wait and enroll October 1. Employees are only allowed to enroll in the Hospital Medical plan when there has been a loss of coverage. The member cannot enroll in dental or vision coverage outside of Open Enrollment even if it was part of the plan in which they lost coverage.

Examples of involuntary loss situations:

- layoffs,
- company discontinuing insurance coverage completely or changing insurance carriers (not just a change in benefits or premiums),
- spouse being fired, or
- divorce.

Examples of loss of Hospital Medical coverage that are **not** considered **involuntary**:

- loss of coverage due to employment strike,
- voluntary resignation or voluntary change in employment, or
- change in benefits or premiums with the insurance plan.

### Voluntary Loss

The Health Insurance Portability and Accountability Act (HIPAA) does allow special enrollment periods when a member or dependent loses other Hospital Medical insurance coverage in certain cases. The employee has **30 days** to request special enrollment when there has been a **voluntary** loss of other coverage. HIPAA is explained in more detail in the HIPAA section of your Member Handbook.

When enrolling in Hospital Medical coverage, the member must complete a *Health Insurance Enrollment Application Form* and attach a letter stating the reason for the loss of coverage from the employer through which coverage was lost. In addition, the letter must provide the employment and termination date as well as the date the insurance coverage ended. If loss of coverage is due to divorce, the member should indicate this on the form and give the exact date

of divorce. If adding family coverage, the member should complete a *Health Insurance Status Change Form* and provide the necessary information on dependents. The member is eligible to enroll in only the Hospital Medical plan under HIPAA. The member cannot enroll in dental or vision coverage outside of Open Enrollment even if it was part of the plan in which they lost coverage.

### Changes Permissible During Open Enrollment

Single or family coverage enrollment

- Add dependent coverage
- Add additional eligible dependents
- Transfer from one PEEHIP Hospital Medical plan to another PEEHIP Hospital Medical plan or an HMO plan
- Transfer from PEEHIP Supplemental plan to PEEHIP Hospital Medical plan
- Apply for PEEHIP CHIP program for eligible dependent children
- Apply for Federal Poverty Discount on hospital medical premiums
- Enroll in Flexible Spending Accounts

### Waiting Periods

Waiting periods on pre-existing conditions will be waived under the following conditions:

- New retiree subscribers from non-participating units who join immediately upon retirement and have Hospital Medical coverage from the non-participating unit
- Subscribers of new units joining PEEHIP
- Subscribers of an HMO plan who elect to transfer to PEEHIP Hospital Medical or PEEHIP Supplemental plan coverage effective October 1 or vice versa
- Any non-subscriber of PEEHIP who elects to enroll in one of the PEEHIP Hospital Medical plans or the HMO plan during the Open Enrollment period

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# Insurance Eligibility

### Guidelines for Insurance Eligibility

Full-time employees and permanent part-time employees are eligible for coverage with PEEHIP.

#### Full-time Employees

A full-time employee is any person employed on a full-time basis in any public institution of education within the State of Alabama. These institutions must provide instruction for any combination of grades K through 14 exclusively, under the auspices of the State Board of Education.

**Permanent Part-Time Employees**

An eligible permanent part-time employee is **not** a substitute or a transient employee. A permanent part-time employee is eligible for PEEHIP if he or she agrees to payroll deduction for a pro rata portion of the premium cost for a full-time employee. The portion is based on the percentage of time the permanent part-time worker is employed.

**Ineligible Employees**

The following employees are not eligible to participate in PEEHIP:

- A seasonal, transient, intermittent or adjunct employee who is hired on an occasional or as-needed basis.
- An adjunct instructor who is hired on a quarter-to-quarter or semester-to-semester basis and/or only teaches when a given class is in demand.
- Board attorneys and local school board members if they are not permanent employees of the institution.
- Contracted employees who may be on the payroll but are not actively employed by the school system.
- Extended day workers hired on an hourly or as needed basis.

## Family Coverage Eligibility

Members can enroll their eligible dependents under PEEHIP by: 1) filing a *Health Insurance Enrollment Application* with the PEEHIP office; or (2) enrolling online at **www.rsa.state.al.us** when the online enrollment option is available.

An eligible dependent is defined as:

1. The employee's lawful spouse, as defined by Alabama law;
2. Unmarried dependent child under the age of 19, only if the child is:
    a. The employee's biological son or daughter;
    b. The employee's legally adopted child[1] (including any probationary period during which the child is required to live with the employee);
    c. The employee's stepchild[1] or foster child[1] fully dependent upon the employee for support and permanently residing in the employee's household in a normal parent-child relationship[2] with no foreseeable or expected termination.
    d. A child related to the employee by blood or marriage who is fully dependent upon the employee for support and permanently residing in the employee's household in a normal parent-child relationship[2]. Appropriate documentation will be required by PEEHIP before child will be enrolled.

[1]Appropriate documentation will be required by PEEHIP before the child can be added.

[2]The term *normal parent-child relationship* is defined as: A relationship where neither the child's natural mother nor natural father live in the employee's household (e.g. when a child's parents are both deceased, totally disabled or their whereabouts are unknown) and the employee and child's relationship has no foreseeable or expected termination.

3. The employee's (a) unmarried dependent child between the ages of 19 and 25 (b) who has his legal residence with the employee, (c) is wholly dependent upon the employee for maintenance and support, (d) and is a registered full-time student at an accredited secondary or postsecondary school, college or university. **All conditions (a), (b), (c) and (d) must be met for the child to be an eligible dependent.**

4. Unmarried dependent child of any age incapable of self-sustaining employment because of a physical or mental handicap and is chiefly dependent on the employee for support. **The handicap must have existed prior to the time the child attained age 19 or age 25 if the child was a full-time student. Also, the child had to be covered as a dependent on the employee's PEEHIP policy before reaching the limiting age. For example, approved incapacitated children can continue on any PEEHIP plans they are on at the time they age out but they are not eligible to be covered on any new PEEHIP plans once they reach the limiting age.** The employee must contact the PEEHIP office and request an Incapacitated Dependent form. Proof of the child's condition and dependence must be submitted to PEEHIP within **31 days** after the date the child would otherwise cease to be covered because of age. PEEHIP may require proof of the continuation of such condition and dependence. If the child is approved as a handicapped child and allowed to stay on the PEEHIP medical plan, the child **cannot** change plans and be covered on other PEEHIP plans, such as an HMO or Optional plan, if he or she has already reached the limiting age (19 or 25).

**Ineligible Dependents**

- Once an "eligible" dependent has "married" or "aged out," that person is ineligible to participate in PEEHIP again as a dependent except subsequently as the spouse of an eligible member.

- **Ex-spouses are not eligible dependents even if a member continues to pay for family coverage. The ex-spouse must be deleted from coverage effective the first day of the month following the date of divorce.**

- Step-children who do not live in the member's household are not eligible dependents.

**Student Dependents**

An eligible student dependent must meet **all** the following requirements:

1. Unmarried and between the ages of 19 and 25

2. Have his or her legal residence with the employee

3. Be wholly dependent upon the employee for maintenance and support

4. Be a registered student in regular full-time attendance at an accredited school.

A dependent must be a full-time student according to the school's status criteria.

Example:

If a dependent is only taking 10 hours and the school requires a student to take 12 hours to be full-time, the dependent would not be an eligible dependent for that term.

If a dependent is attending more than one school during a given term and is not considered full-time at any one school, the student must be taking at least 12 hours total to be eligible for that term.

If a student is in full-time status for at least one full regular term (not a mini-term) during a school year, he or she can receive one term off during that same school year and still remain a dependent on subscriber's contract.

Example:

If a dependent is a full-time student for fall term and decides to take off the spring term, he or she is eligible to remain on the subscriber's contract through the spring term. Beginning the summer term, the dependent would be required to be a full-time student again or the student loses eligibility as a student.

**A dependent cannot take off or be part-time more than one term during a school year and remain on the subscriber's contract. A dependent must be full-time two out of three semesters or three out of four quarters during a school year.**

When a dependent graduates from school, the dependent loses student dependent status at the end of the month in which he or she graduates regardless of the dependent's age. The dependent is not given a "free term" after graduation unless the dependent has been accepted to a postgraduate school and will begin classes within 90 days. Proof of acceptance is required by PEEHIP.

When a dependent is no longer eligible for coverage as a dependent, he or she may be eligible to continue their health insurance coverage under **COBRA**. To elect coverage under COBRA, the member or dependent must notify PEEHIP within **60 days** from the date the dependent is no longer eligible for coverage.

The PEEHIP office handles the student verification process for the PEEHIP Hospital Medical plan and the Optional plans. PEEHIP sends a student verification letter to the member a few months before the student dependent's birthday. The member must then use one of two methods to update the student dependent through PEEHIP: 1) phone method; or 2) online system method.

1) **Phone Update**: Members can call the PEEHIP Student Verification phone line at (800) 214-2158 extension 1460 and answer the automated questions verbally. PEEHIP records the information and a staff member updates your account and transmits the student verification to the insurance carriers. The insurance carriers will update their records within 5-7 days.

2) **Online System Update**: Members also have the option of updating their student dependent through the RSA member portal by going to the RSA Web site at www.rsa.state.al.us. Select **Member Services**, then select **View/Change Student Status Data** and follow the instructions on the screen. The online system is only available to PEEHIP members for 90 days from the date they receive the student verification letter.

**If PEEHIP is given incorrect information, the member is responsible for all claims incurred by the student.**

**If a student dependent's status is not updated in a timely manner, the student dependent will be cancelled and PEEHIP will require written verification from the registrar's office before the student can be reinstated. If the student dependent's status changes during the year, the member is responsible for notifying the PEEHIP office.**

## Newly Acquired Dependents - Single Coverage

### Marriage

A member with single coverage who marries and wishes to acquire family coverage must submit written notification to PEEHIP within **31 days** of the date of marriage. The effective date of coverage may be the date of marriage or the first day of the following month. The 270-day waiting period on pre-existing conditions will be waived if proof of previous coverage is received and approved by the PEEHIP office. Prior notification is not required.

If PEEHIP does not receive written notification within 31 days of the date of marriage, the eligible dependent will be added as of the date of notification or first of the month following notification. The eligible dependent will be required to serve a 270-day waiting period on pre-existing conditions unless proof of previous coverage is received and approved by the PEEHIP office.

**Newborn**

A member with single coverage who desires family coverage due to the birth of a child must submit written notification to PEEHIP within **31 days** of the date of birth. The effective date of coverage *may* be the date of birth or the first day of the following month. A waiting period on pre-existing conditions will be waived for the newborn child if the effective date is the date of birth. Prior notification is not required. ***If a newborn is not covered on the date of birth, claims for the newborn at the time of birth are not paid.***

When adding family coverage, a member can add all eligible dependents to the policy. However, the newly added dependents may be subject to the 270-day waiting period on pre-existing conditions.

If PEEHIP does not receive written notification within 31 days of the date of birth, the eligible dependent(s) will be added as of the date of notification. In this case, the eligible dependent(s) is required to serve a 270-day waiting period on pre-existing conditions unless proof of previous coverage is received and approved by the PEEHIP office.

## Newly Acquired Dependents - Family Coverage

If the member has family coverage, the member may enroll a new dependent(s) by completing and mailing a *Health Insurance Status Change Form* to the PEEHIP office within **31 days** of acquiring the dependent(s). Prior notification is not required. Application for dependent coverage must be made by the employee and approved and processed by PEEHIP prior to the payment of any claims.

**Stepchildren**

To add a stepchild, the member must attach to the *Health Insurance Enrollment Application* documentation that the stepchild is residing in the household. Acceptable documentation would be school records, divorce papers, etc.

**Other Dependent Children**

When adding a dependent child other than the member's biological child or stepchild, the member must attach to the *Health Insurance Enrollment Application* documentation of custody or guardianship and provide information as to the relationship to the member. The dependent must be related to the employee by blood or marriage and must be fully dependent upon the employee for support and permanently residing in the employee's household in a normal parent-child relationship. In addition, PEEHIP requires appropriate documentation as to the whereabouts of the natural mother and father, such as custody or guardianship papers, notarized statement, etc. If custody is temporary, the dependent child must have resided in the member's household for at least one year before the dependent can be considered for coverage.

**Dependents with Different Last Names**

If a husband and wife have different last names, the member must attach to the *Health Insurance Enrollment Application* a copy of the marriage certificate.

If biological children have different last names, the member must attach to the *Health Insurance Enrollment Application* a copy of the birth certificate.

***Enrollments cannot be processed without the appropriate documentation as explained above.***

***PEEHIP is not bound by a court order to insure dependents who do not meet PEEHIP guidelines.***

# Updating Information

**Name and Social Security Number Changes**

Currently, PEEHIP determines a member's name for insurance purposes from the TRS Form 100 enrollment form or, the *Health Insurance Enrollment Application.* In the near future, PEEHIP will be updating names from information received from the Social Security office. Therefore, the name on all insurance and TRS forms must be the same as the name on the Social Security card.

PEEHIP requires a copy of the member's Social Security card before a name or social security number change can be made.

**ADDRESS CHANGES**

To change an address, a member must notify PEEHIP **in writing** or update through the online process. To change your address in writing, you should complete an *Address Change Notification Form* which can be downloaded from the RSA web site. PEEHIP will also accept a letter with the old address, new address, insured's name and Social Security number.

**The PEEHIP department cannot accept an address change by phone.** All address changes should be made on the address change cards provided by the U.S. Post Office or the *Address Change Form Notification* provided by RSA. The card must then be mailed to **PEEHIP** for the actual change to occur.

To change your address online, go to the RSA Website at **www.rsa.state.al.us** and make an address change. Select the **Member Services** option on the left side of the home page and follow the instructions. This address will automatically transmit to the insurance carriers and also update your address with the Teachers' Retirement System and RSA-1 if you are a participant in those accounts. However, the address change you make through the RSA online system will not change your address with your employer. You must contact your employer to have your address changed in their system.

# COBRA COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) requires PEEHIP and most other group health plans to offer employees and their families the opportunity for a temporary extension of health coverage. The continuation of coverage is offered at group rates in certain instances where coverage under PEEHIP would otherwise end.

All public education employees of the State of Alabama who are covered under the PEEHIP group health insurance have the right to choose continuation of coverage if the employee loses group health coverage due to a reduction in hours of employment or because of a resignation or termination of employment (for reasons other than gross misconduct on the part of the employee).

Each public education institution has the responsibility by law to notify the PEEHIP office immediately when an employee loses group health coverage due to the employee's:

- death
- termination of employment
- or reduction in hours

**Leave of Absence**

A member who goes on an authorized leave of absence without pay can continue group health coverage for up to two years of authorized leave before he or she would be required to enroll in continuation of coverage under the COBRA provisions. A member on an approved leave of absence can continue the health insurance coverage for two years and then can continue the health insurance coverage for an additional 18 months under the COBRA provisions.

**COBRA Compliance**

The sanctions imposed under the auspices of COBRA can be quite severe, making a determination of compliance greatly important. It is the employer's responsibility to notify PEEHIP within a maximum of 30 days of an employee's termination, death or reduction in hours. The employer must notify the PEEHIP office by entering a termination date in the employer portal before the next payroll cycle. Employers must key the termination date in the employer portal for each employee who loses insurance coverage due to resignation or termination of employment or reduction in hours, even if the employee does not want to continue the coverage or is transferring allocation to a spouse.

It is the employee's or dependent's responsibility to notify PEEHIP within a maximum of 60 days when the **dependent** needs continuation coverage under COBRA.

COBRA allows the employer a maximum of 30 days to notify PEEHIP of the above named qualifying events. However, the employer's immediate notification to PEEHIP will help reduce the amount of time the plan is exposed to adverse risk and potential premium increases.

**Termination for Gross Misconduct**

If an employer terminates an employee for *gross misconduct*, then PEEHIP is **not** required to provide continuation of coverage under the provisions of COBRA. However, the employer must still notify the PEEHIP office of the termination by entering the termination information via the employer portal.

**Eligibility**

**Under COBRA, the employee, ex-spouse or dependent family member has the responsibility to inform PEEHIP within 60 days of a divorce, legal separation, or a child losing dependent status under the Plan and must obtain a *Continuation of Coverage Application Form*. PEEHIP may be notified by phone or in writing.**

A dependent's coverage ends on the last day of the month in which the dependent becomes ineligible by turning age 19 or 25 if a full time student or by marriage, divorce or legal separation.

When PEEHIP is notified of a qualifying event, PEEHIP will in turn notify the eligible member that he or she has the right to choose continuation of coverage. It is important to note that the eligible member has 60 days from the date he or she would lose coverage because of one of the qualifying events to inform PEEHIP that he or she wants continuation of coverage.

If the eligible member does not choose continuation of coverage, his or her PEEHIP group health insurance coverage will end the last day of the month in which the member becomes ineligible.

If a member and/or dependent become entitled to Medicare after electing COBRA coverage, he or she is no longer eligible to continue the COBRA coverage. However, dependents on the contract will be allowed to continue COBRA coverage up to a total of 36 months from the date of the original qualifying event.

**Continuation of Coverage**

If the eligible member chooses continuation of coverage, PEEHIP is required to give the member coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members and is the same coverage he or she had prior to the qualifying event.

COBRA requires that the eligible member be afforded the opportunity to maintain continuation of coverage for 18 months due to a termination of employment or reduction in hours. COBRA requires that eligible dependents who become ineligible for reasons such as aging out, non-student status or divorce be afforded an opportunity to maintain coverage for 36 months.

COBRA also provides that a member's continuation of coverage may be cut short for any of the following five reasons:

1. PEEHIP no longer provides group health coverage to any of its employees.

2. The premium for continuation of coverage is not paid by the member when payment is due, or the premium payment is insufficient.

3. The member becomes covered under another group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition.

4. The member or dependent becomes entitled to Medicare after COBRA benefits begin.

5. The member becomes divorced from a covered member and subsequently remarries and is covered under the new spouse's group health plan, which does not contain any exclusions or limitations with respect to pre-existing conditions.

An eligible member does not have to show that he or she is insurable to choose continuation of coverage. However, under COBRA, he or she is required to pay the full monthly premium for continuation of coverage.

Cobra coverage is available for 18 months for a terminated employee and their dependents and 36 months for a dependent who becomes ineligible for reasons such as aging out, non-student status, or divorce.

If a member who is on COBRA dies before the 18 months have lapsed and the member's family is covered under COBRA, the eligible covered family members can continue the COBRA coverage up to a total of 36 months from the date of the original qualifying event.

**Dependent Coverage**

A spouse of an employee covered by PEEHIP has the right to choose continuation of coverage if the spouse loses group health coverage under the Plan for any of the following reasons:

- death of the employee
- termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment.
- divorce or legal separation
- employee's eligibility for Medicare

In the case of a dependent child of an employee covered by PEEHIP, he or she has the right to continuation of coverage if group health coverage under the Plan is lost for any of the following reasons:

- death of a parent

- termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the employer
- parents' divorce or legal separation
- parent becomes eligible for Medicare
- dependent ceases to be a *dependent child* under the Plan

**Members on COBRA Who Return to Work**

When a member who is enrolled in PEEHIP under COBRA returns to work and does not have a break in coverage, the member is not allowed to change coverage until the Open Enrollment period.

If a member chooses not to continue their insurance coverage under COBRA and has a break in coverage, the member must complete a new enrollment application when he or she is re-employed in public education.

*Exception*: Employees enrolled in one or more Optional plans while on COBRA can add the remaining Optional plans when he or she becomes eligible for a full allocation. However, employees enrolled in one or more Optional plans while on COBRA cannot enroll in a Hospital Medical plan until Open Enrollment.

**Can COBRA Coverage be Extended for Covered Members who Become Disabled?**

Yes. In certain circumstances, COBRA can be extended for covered members who become disabled. If a covered member becomes disabled under Title 11 (OASDI) or Title XVS (SSI) of the Social Security Act during the first 60 days after the employee's termination of employment or reduction in hours, the 18-month period may be extended to 29 months on the date the disabled individual becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself.

In order for this disability extension to apply, you must notify the PEEHIP office of Social Security's determination within 60 days after the date of the determination and before the expiration of the 18-month period. You must also notify PEEHIP within 30 days of any revocation of Social Security disability benefits.

The cost of COBRA after the 18th month will be 150% of the full cost of coverage under the plan, assuming that the disabled individual elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

For spouses and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. The 36-month period will run from the original date of the termination of employment or reduction in hours.

## Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), known as the Kassebaum/Kennedy bill, was signed into law on August 21, 1996. HIPPA protects Americans who move from one job to another, who are self-employed, or who have pre-existing medical conditions. HIPAA went into effect for the PEEHIP Hospital Medical Plan and the HMO plans beginning October 1, 1997.

HIPAA provides for increased health coverage portability for our members with fewer restrictions on pre-existing conditions, certification requirements for prior health coverage, and special enrollment periods. HIPAA provides for other benefits such as guaranteed availability and renewability of health insurance coverage.

HIPAA includes the following:

- requires plans to give credit toward a member's or dependent's pre-existing condition limitations period for prior *creditable coverage*
- defines what can be a *pre-existing condition*
- requires plans, on an individual's request, to certify the period of previous insurance coverage
- limits the period during which pre-existing condition limitations can be imposed
- prohibits the use of pre-existing condition limitations for pregnancies, adopted children and newborns

**Credit Must Be Given for Creditable Coverage**

Blue Cross and Blue Shield of Alabama will mail a Certificate of Creditable Coverage, which provides evidence of prior health coverage. These certificates are mailed to all members when coverage under the Hospital Medical Plan ends. Certificates can be used to demonstrate creditable coverage to the member's new plan or issuer and are furnished automatically to members and upon request by an individual within 24 months after the coverage ends.

PEEHIP will accept the Certificates of Creditable Coverage for members enrolling outside of the Open Enrollment period and will reduce their pre-existing condition exclusion period by the length of the total period of prior creditable coverage. If there is a break in coverage longer than 63 days, PEEHIP is not required to accept the Certificate of Creditable Coverage. Members must send the certificate to the PEEHIP office to receive credit for previous coverage.

**Special Enrollment Periods**

HIPAA requires group health plans to provide special enrollment periods during which certain individuals who previously declined health coverage are allowed to enroll. A special enrollee is not treated as a late enrollee. The 9-month pre-existing condition waiting period may be applied to a special enrollee but must be reduced by the special enrollee's creditable coverage. Special enrollment occurs when:

- an individual with other insurance coverage loses that coverage
- a person becomes a dependent through marriage
- a birth of a dependent child
- an adoption or placement of adoption of a child under the age of 18

These individuals are not required to wait until the Open Enrollment period to enroll. This special enrollment period is available to employees and their dependents who meet certain requirements:

1. The employee or dependent must otherwise be eligible for coverage under the terms of their plan.

2. When the PEEHIP coverage was previously declined, the employee or dependent must have been covered under another group health plan or must have had other health insurance coverage.

3. If the other coverage is COBRA continuation of coverage, the special enrollment can only be requested after exhausting COBRA continuation of coverage.

4. If the other coverage is not COBRA continuation of coverage, special enrollment can only be requested after losing eligibility for the other coverage or after cessation of employer contributions for the other coverage. In each case, the employee has **30 days** to request special enrollment.

**An individual does not have a special enrollment right if the individual loses the other coverage for the following reasons:**

1. as a result of the individual's failure to pay premiums

2. for cause (such as making a fraudulent claim)

3. if other coverage has an increase in premiums or a change in benefits

These examples do not qualify as a loss of coverage under the HIPAA Federal guidelines.

The special enrollment for new dependents can occur if a person has a new dependent by birth, marriage, adoption, or placement for adoption. The election to enroll must be made within **30 days** following the birth, marriage, adoption, or placement for adoption.

**If the request is not made within 30 days of the loss of coverage, the special enrollment benefit does not apply. In addition, the coverage effective date must be within 30 days of the loss of coverage.**

## Privacy Notice

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.***

The Public Education Employees' Health Insurance Plan (the "Plan") considers personal information to be confidential. The Plan protects the privacy of that information in accordance with applicable privacy laws, as well as its own privacy policies.

The Plan is required by law to take reasonable steps to ensure the privacy of your health information and to inform you about:

- the Plan's uses and disclosures of your health information
- your privacy rights with respect to your health information
- the Plan's obligations with respect to your health information
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services
- the person or office to contact for further information about the Plan's privacy practices

**Effective Date of Notice:** This notice was effective as of April 14, 2003.

## How the Plan Uses and Discloses Health Information

This section of the notice describes uses and disclosures that the Plan may make of your health information for certain purposes without first obtaining your permission as well as instances in which we may request your written permission to use or disclose your health information. The Plan also requires their business associates to protect the privacy of your health information through written agreements.

**Uses and disclosures related to payment, health care operations and treatment** The Plan and its business associates may use your health information without your permission to carry out payment or health care operations. The Plan may also disclose health information to the Plan Sponsor, PEEHIP, for purposes related to payment or health care operations.

**Payment** includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, review for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell an insurer what percentage of a bill will be paid by the Plan.

**Health care operations** include but are not limited to underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts, disease management, case management, conducting or arrangement for medical review, legal services and auditing functions, including fraud and abuse programs, business planning and development, business management and general administrative activities. It also includes quality assessment and improvement and reviewing competence or qualifications of health care professionals. For example, the Plan may use medical benefit claims information to conduct a review of the accuracy of how benefit claims are being paid.

**Other uses and disclosures that do not require your written authorization.** The Plan may disclose your health information to persons and entities that provide services to the Plan and assure the Plan they will protect the information or if it:

- Constitutes summary health information and is used only for modifying, amending or terminating a group health plan or obtaining premium bids from health plans providing coverage under the group health plan
- Constitutes de-identified information
- Relates to workers' compensation programs
- Is for judicial and administrative proceedings
- Is about decedents
- Is for law enforcement purposes
- Is for public health activities
- Is for health oversight activities
- Is about victims of abuse, neglect or domestic violence
- Is for cadaveric organ, eye or tissue donation purposes
- Is for certain limited research purposes
- Is to avert a serious threat to health or safety
- Is for specialized government functions
- Is for limited marketing activities

**Additional disclosures to others without your written authorization.** The Plan may disclose your health information to a relative, a friend or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, the Plan may confirm whether or not a claim has been received and paid. You have the right to request that this kind of disclosure be limited or stopped by contacting the Plan's Privacy Official.

**Uses and Disclosures Requiring Your Written Authorization**. In all situations other than those described above, the Plan will ask for your written authorization before using or disclosing your health information. If you have given the Plan an authorization, you may revoke it at any time, if the Plan has not already acted on it. If you have questions regarding authorizations, contact the Plan's Privacy Official.

## Your Privacy Rights

This section of the notice describes your rights with respect to your health information and a brief description of how you may exercise these rights. To exercise your rights, you must contact the Plan's Privacy Official at 1-800-214-2158.

**Restrict Uses and Disclosures.** You have the right to request that the Plan restricts uses and disclosure of your health information for activities related to payment, health care operations and treatment. The Plan will consider, but may not agree to, such requests.

**Alternative Communication.** The Plan will accommodate reasonable requests to communicate with you at a certain location or in a certain way. For example, if you are covered as an adult dependent, you may want the Plan to send health information to a different address than that of the Employee.

**Copy of Health Information.** You have a right to obtain a copy of health information that is contained in a "designated record set" – records used in making enrollment, payment, claims adjudication, and other decisions. The Plan may provide you with a summary of the health information if you agree in advance to the summary. You may also be asked to pay a fee of $1.00 per page based on the Plan's copying, mailing, and other preparation costs.

**Amend Health Information.** You have the right to request an amendment to health information that is in a "designated record set." The Plan may deny your request to amend your health information if the Plan did not create the health information, if the information is not part of the Plan's records, if the information was not available for inspection or the information is accurate and complete.

**List of Certain Disclosures.** You have the right to receive a list of certain disclosures of your health information. The Plan or its business associates will provide you with one free accounting each year. For subsequent requests, you may be charged a reasonable fee.

**Right to A Copy of Privacy Notice**. You have the right to receive a paper copy of this notice upon request, even if you agreed to receive the notice electronically.

**Complaints**. You may complain to the Plan or the Secretary of HHS if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

## The Plan's Responsibilities

The Plan is required by a federal law to keep your health information private, to give you notice of the Plan's legal duties and privacy practices, and to follow the terms of the notice currently in effect.

### This Notice is Subject to Change

The terms of this notice and the Plan's privacy policies may be changed at any time. If changes are made, the new terms and policies will then apply to all health information maintained by the Plan. If any material changes are made, the Plan will distribute a new notice to participants and beneficiaries.

**Your Questions and Comments** If you have questions regarding this notice, please contact the Plan's Privacy Official at 1-800-214-2158.

# BENEFIT CONDITIONS

To qualify as plan benefits, medical services and supplies must meet the following:

1. They must be furnished after your coverage becomes effective;

2. Services or supplies for any pre-existing condition must be furnished after the 9-month (270 days) pre-existing condition exclusion period;

3. We must determine before, during or after services and supplies are furnished that they are medically necessary;

4. PPO benefits must be furnished while you are covered by this plan and the provider must be a PPO Provider when the services or supplies are furnished to you;

5. Separate and apart from the requirement in paragraph 4. above, services and supplies must be furnished by a provider (whether a Preferred Provider or not) who is recognized by Blue Cross Blue Shield of Alabama as an approved provider for the type of service or supply being furnished. For example, Blue Cross reserves the right not to pay for some or all services or supplies furnished by certain persons who are not Medical Doctors (M.D.s), even if the services or supplies are within the scope of the provider's license. Call Customer Service if you have any question whether your provider is recognized by us as an approved provider for the services or supplies you plan on receiving;

6. Services and supplies must be furnished when the plan and your coverage both are in effect and fully paid for. No benefits will be provided for services you receive after the plan or your coverage ends, even if they are for a condition which began before the plan or your coverage ends.

# HEALTH BENEFITS

All benefits are subject to all deductibles, conditions, limitations and exclusions of the plan.

**BEFORE YOUR HOSPITAL ADMISSION--CAUTION:** One of several requirements for hospital benefits is that Blue Cross certify the medical necessity of your hospital stay in advance, except for emergencies and when you are admitted to a Concurrent Utilization Review Hospital by a Preferred Medical Doctor. Emergency admissions require notice to Blue Cross within 48 hours and must also be certified by Blue Cross as both medically necessary and as an emergency admission. You may appeal these decisions. **Failure to obtain Blue Cross certificate of medical necessity will result in no benefits being paid for your hospital stay or the admitting physician.** Just because Blue Cross certifies a hospital admission as medically necessary does NOT mean Blue Cross has decided to pay benefits for it. For example, the admission may be for a pre-existing condition or any other excluded condition.

## Inpatient Hospital Benefits

1. Bed and board and general nursing care in a semiprivate room; **or**
2. Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them; **and**
3. Use of operating, delivery, recovery, and treatment rooms and the equipment in them;
4. Administration of anesthetics by hospital employees and all necessary equipment and supplies;
5. Casts and splints, surgical dressings, treatment and dressing trays;
6. Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and x-rays;
7. Physical therapy, hydrotherapy, radiation therapy and chemotherapy;
8. Oxygen and equipment to administer it;
9. All drugs and medicines used by you and administered in the hospital;
10. Regular nursery care and diaper service for a newborn baby while its mother has coverage;
11. Blood transfusions administered by a hospital employee.

## Inpatient Hospital Benefits for Maternity

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Note:** Newborns who remain hospitalized after the mother is discharged will require certification of medical necessity. The newborn child must be added to the PEEHIP policy before any claims will be paid. Member must complete the PEEHIP Health Insurance Status Change Form to have the newborn added to his or her PEEHIP policy.

## Outpatient Facility Benefits

1. Emergency treatment of an accidental injury;
2. Chemotherapy and radiation therapy;
3. IV therapy;
4. Hemodialysis (hospital only, benefits for Participating Renal Dialysis Facilities is "Other Covered Services");
5. X-rays, lab and pathology services;
6. Medical emergency;
7. Surgery.

## Preferred Home Health Care

1. Preferred Home Health Care benefits which are home IV therapy, intermittent home nursing visits by an R.N. or L.P.N. and home phototherapy for newborns, must be ordered by your physician and provided by a Preferred Home Health Care Provider. When these services are provided outside of Alabama, benefits are paid **only** if precertification is obtained by calling 1-800-821-7231.

2. Preferred Hospice benefits which are physician home visits, medical social services, physical therapy, inpatient respite care, home health aide visits from one to four hours, durable medical equipment and symptom management, must be furnished by a Preferred Hospice to a member certified by his physician to have less than six months to live. When these services are provided outside of Alabama, benefits are paid **only** if precertification is obtained by calling 1-800-821-7231.

**Note:** Private Duty Nursing Services are not covered under Preferred Home Health Care.

## Physician Benefits

1. Physician's services for surgery which includes preoperative and postoperative care, reduction of fractures and endoscopic procedures, maternity deliveries and heart catheterization.

2. Anesthesia by a physician for surgery or obstetrical care when given by other than the surgeon, obstetrician or hospital employee;

3. Second surgical opinion services by a physician;

4. Obstetrical care by a physician for childbirth, pregnancy, and the usual care before and after those services;

5. Inpatient visits by a physician while you're a hospital patient for other than surgery, obstetrical care, mental health, or radiation therapy except for an unrelated condition;

6. Consultation for a medical, surgical or maternity condition by a specialty physician but only one for each hospital stay;

7. Diagnostic lab, x-ray and pathology services in a physician's office when related to covered services;

8. Radiation therapy and chemotherapy by a physician;

9. Care by a physician in the emergency room of a hospital for other than surgery or maternity;

10. Exam, diagnosis, and treatment for an illness or injury in a physician's office;

11. Treatment of natural teeth injured by a force outside your mouth or body, if service is received within 12 months of the injury;

12. Dentist's or oral surgeon's services for treatment of fractures and dislocations of the jaw and for excision of dentigenous cysts, oral radicular cysts or bone tumors.

Your physician or provider may bill another group health plan for any difference between the amount Blue Cross pays and his charge for any service which is a benefit of this plan.

## Enhanced Preventive Care Services (Benefits are only available when provided by a PPO)

1. Inpatient visits for routine newborn care;
2. Six office visits for the first year of a baby's life; three office visits during the second year of the child's life; annual exams for ages two through six; one exam every two calendar years age seven through 18 (subject to copay);
3. One TB skin testing before age one; once for ages one through four; and once for ages 14 through 18;
4. One lead screening by age two;
5. One urinalysis by age five and once for ages 12 through 17;
6. One office visit each calendar year age 19 and over (subject to copay);
7. One routine pap smear each calendar year for females;
8. One complete blood count each calendar year;
9. One cholesterol test every five calendar years;
10. One baseline mammogram for females ages 35-39; one mammogram a year for ages 40 and over; see Mastectomy and Mammograms (later in this booklet) for additional information;
11. One prostate specific antigen test each calendar year for males age 40 and over;
12. One sigmoidoscopy every three calendar years for age 50 and over;
13. One hemocult stool check each calendar year for age 50 and over;
14. Routine immunizations are covered if:
    - administered to prevent diphtheria, tetanus, pertussis, polio, rubella, mumps, measles, Hib, hepatitis A, hepatitis B, chicken pox, meningococcal disease, rotavirus influenza (but not flu mist); or,
    - administered during the first 24 months of life to prevent invasive pneumococcal disease.

## Baby Yourself Program

If you or your spouse is pregnant, "Baby Yourself" offers individual care by a registered nurse and useful gifts that educate and support healthy habits. Please call the Blue Cross nurses at 1-800-222-4379 (or 733-7065 in Birmingham) as soon as you find out you are pregnant. Begin care for you and your baby as early as possible and continue throughout your pregnancy. Your baby has the best chance for a healthy start by early, thorough care while you are pregnant. If you fall into one of the following risk categories, please tell your doctor and your Baby Yourself nurse:

- ages 35 or older
- high blood pressure
- diabetes
- history of previous premature births
- multiple births (twins, triplets, etc.)

## Other Covered Services

1. Semiprivate room and board, general nursing care, and all necessary hospital services and supplies when your inpatient hospital benefits are all used.

2. Physical therapy and hydrotherapy given by a licensed physical therapist. Preferred Physical Therapists may be required to precertify services during the course of your treatment. If so, the Preferred Physical Therapist will initiate the precertification process for you. If precertification is denied, you will have the right to appeal the denial.

3. Artificial arms and other prosthetics; leg braces and other orthopedic devices.

4. Medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints.

5. Professional ambulance service to the closest hospital that could treat the condition.

6. The less expensive for rental or purchase of durable medical equipment such as wheelchairs and hospital beds.

7. Hemodialysis services of a Participating Renal Dialysis Facility.

8. Phase I therapy and exams for TMJ disorders according to the guidelines of the American Academy of Craniomandibular Disorders.

9. Speech therapy performed by a qualified speech therapist if rendered as a result of injury or disease which occurred while the member was covered by PEEHIP. Speech therapy is not covered for delayed language development or articulation disorders. Speech therapy is limited to 30 sessions per member each calendar year.

10. Non-surgical care of temporomandibular joint (TMJ) disorders, including office visits and adjustments to the orthopedic appliance. Benefits for non-surgical care of TMJ are limited to a lifetime maximum payment of $1,000 per member.

11. Surgical care of temporomandibular joint (TMJ) disorders must be pre-approved at least three weeks prior to surgery before benefits are available. The guidelines and stipulations established are as follows:

    - The physician must send a completed Predetermination of Benefits Request Form to Blue Cross and a second surgical opinion at least three weeks before the surgery.

    - Blue Cross will review the request and decide whether or not the surgery is medically necessary and Blue Cross will tell the physician of their decision before the surgery.

    - A second surgical opinion is required. PMD physicians will secure second surgical opinions according to the PMD guidelines. Non-PMD physicians must secure the second surgical opinion from a provider in a similar specialty. The responsibility for the second surgical opinion from a Non-PMD physician will fall on the patient.

    - **If surgery for TMJ disorders is not pre-approved using these guidelines, there will be no benefits.**

12. Occupational therapy services when the following conditions are met:

    a. The services must be medically necessary and performed by a licensed occupational therapist.

    b. The services must be related to the hand and/or treatment of lymphedema, and must be of a type that is covered under the occupational therapy program. Call Customer Service at 1-800-327-3994 to determine what specific diagnostic codes and procedures are covered.

    If you see a Preferred Occupational Therapist, the therapist will bill Blue Cross and Blue Cross will pay him or her directly. By contrast, if you see an occupational therapist who is not a Preferred Occupational Therapist, you may have to file your claim, and Blue Cross will pay you directly.

    Preferred Occupational Therapists may be required to precertify services during the course of your treatment. If so, the Preferred Occupational Therapist will initiate the precertification process for you. If precertification is denied, you will have the right to appeal the denial.

13. Allergy testing and treatment.

14. Chiropractic services. Participating Chiropractors may be required to precertify services during the course of your treatment. If so, the Participating Chiropractor will initiate the precertification process for you. If precertification is denied, you will have the right to appeal the denial.

## Supplemental Accident Benefits

Supplemental accident rider benefits are provided when a member suffers accidental bodily injury. Services for the injury must be provided within 90 days after the accident, and ordered by your physician. The maximum benefit is $500 per accident.

1. Physician services for medical and surgical treatment;

2. Hospital outpatient services;

3. X-ray and laboratory exams and diagnostic tests;

4. Professional ambulance service to the closest hospital that could treat the condition;

5. Anesthetics;

6. Oxygen;

7. Treatment by a physician of injuries to natural teeth, including replacement of the injured teeth (implants and braces are not covered);

8. The less expensive for purchase or rental of durable medical equipment.

**Supplemental Accident Benefits exclude:**

1. Eye refractions;

2. Fitting or furnishing of eyeglasses;

3. Services for any condition other than treatment for and within 90 days of an accidental injury;

4. Services if covered by inpatient or outpatient hospital benefits;

5. Private duty nursing services;

6. Charges for accidental injury to natural teeth caused by a force inside the body or the oral cavity (mouth) including, but not limited to, biting, chewing, clenching and grinding;

7. Prescription drugs and medicines;

8. Inpatient expenses from a hospital which includes your hospital deductible, private room difference and non-covered services.

9. Services and expenses from a Doctor of Chiropractic (D.C.).

## Mental Health and Substance Abuse Preferred Provider Organization (PPO)

The Mental and Nervous PPO provision runs on an October 1 through September 30 plan year, rather than the January through December calendar year.

When the Mental Health and Substance Abuse PPO benefits are used, the member or eligible dependent receives expanded coverage for:

- Outpatient Care
- Individual Therapy/Counseling
- Family Therapy/Counseling
- Emergency Services
- Hospital Based Treatment
- Alcohol and Drug Abuse Counseling
- Residential Treatment for Alcohol and Drug Abuse

When one of the Certified Regional Mental Health Centers is visited, benefits are provided for (subject to deductible, copays and limitations listed in the Summary of Benefits):

- Outpatient treatment for mental and nervous disorders
- Substance abuse intensive outpatient treatment
- Mental illness day hospitalization, intensive day treatment and supportive day treatment are available at certain PPO Mental Health Centers.

Inpatient psychiatric care and residential substance abuse treatment received through this PPO will be covered at 100% after a copay. **Inpatient substance abuse treatment is limited to one admission per benefit period and two admissions per lifetime per covered member. The admit date determines which benefit period a claim falls into.** The member may use a combination of the PPO benefits and regular inpatient hospital benefits up to a 30-day limit per benefit year. For example: If the member or eligible dependent is treated for crisis stabilization in a non-PPO facility for four days and uses regular inpatient hospital benefits and then is transferred to a PPO facility for rehabilitative care, he/she would have 26 days available for that benefit year. However, the hospital stay must be precertified as medically necessary before **any** benefits are available. (There is one 30-day limit for both psychiatric care and substance abuse treatment.) See Summary for copays.

Once the 30-day limit has been met for the year, coverage will end until the beginning of the following plan year.

**To take advantage of the PPO benefits, contact the Community Mental Health Center nearest you. When you make an appointment identify yourself as having the Teacher's Mental Health and Substance Abuse PPO. Please remember that you must first visit one of the Certified Community Mental Health Centers and any hospital admission must be precertified by the Claims Administrator. Trips to any of the other approved facilities must be referred or precertified by one of the Centers. Precertification of a hospital admission must be given within 24 hours or no later than the next workday, including emergency cases. A list of the Certified Community Mental Health Centers is located in the back of this booklet.**

Non-PPO benefits are available only for short-term crisis intervention and only until the patient is stable enough to be moved to a PPO hospital. See the Summary of Health Benefits for deductible and payment information.

**Note:** Services rendered at PPO facilities are not subject to the inpatient deductible.

# PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are administered by Express-Scripts, Inc. (ESI). All benefits are subject to copays, conditions, limitations and exclusions of the plan.

1. In Alabama, benefits are only for prescriptions purchased from Participating Pharmacies. Participating Pharmacies bill ESI and ESI pays them. You pay only the copay or the cost of the drug if it is less than the copay. You can determine whether a pharmacy is a Participating Pharmacy by going to the website **www.express-scripts.com**.

2. Benefits for specialty medications are provided exclusively through Curascript specialty pharmacy. The Curascript Customer Service telephone number is 1-888-773-7376. Specialty medicatons are generally defined as high cost oral, injectable and infused drugs which treat complex, chronic or life-threatening conditions and require patient specific dosing, ongoing monitoring for effective patient adherence, periodic lab and/or diagnostic testing for continued treatment determination, and specialized handling and distribution.

3. To be eligible for benefits, drugs must be medically necessary, legend drugs prescribed by a physician and dispensed by a pharmacy. Legend drugs are medicines which must by law be labeled, "Caution: Federal Law prohibits dispensing without a prescription." Compound drugs are covered if at least one of the drugs in the compound is a legend drug. Oral contraceptives qualify for benefits when prescribed for a medical condition but not when prescribed for birth control. In some cases, drugs may also require prior authorization. Your participating Pharmacist will advise if this is a requirement.

4. Drugs can be dispensed in a maximum of a 34-day supply for each drug or refill. Refills are allowed only after 60% of the previous prescription has been used, e.g., 21 days into a 34-day supply.

5. The first fill of a maintenance drug can be dispensed for up to a 34-day supply. Refilled maintenance drugs can be dispensed in the greater of a 90-day supply or 100 unit doses when the prescription is written for a 90-day supply. Also, there cannot be more than a 130-day lapse from the time that the maintenance drug prescription has been purchased and filed through the PEEHIP Express Scripts prescription plan. Approved maintenance list drugs may be purchased up to a 90-day or 100 unit dose supply with one copay when the drug is prescribed by the physician as a maintenance drug. You can determine if a drug is on the maintenance list by going to www.express-scripts.com or calling your Participating Pharmacy. In order for a drug to be considered for the Maintenance List, it must meet all the following criteria as determined by an expert panel of physicians and pharmacists:

- Drug has a low probability for dosage or therapy changes due to side effects, serum drug concentration monitoring, or therapeutic response over a course of prolonged therapy;

- Drug's most common use is to treat a chronic disease state;

- Drug is administered continuously rather than intermittently;

- Excluded are dosage forms that are not practical for large dispensing quantities (such as liquids) and drugs known for life-threatening toxicity when taken as an intentional overdose;

- New drugs that are classified as non-formulary are not eligible to be added to the PEEHIP Express Scripts maintenance list.

6. Drugs dispensed from Non-Participating Pharmacies outside of Alabama have the same pharmacy copays as drugs dispensed from Participating Pharmacies. However, you must pay any difference above the amount ESI would pay a Participating Pharmacy. You must file a manual claim form with ESI and ESI will pay you direct.

7. All claims must be received within 365 days after medications are filled in order for the claim to be considered for payment.

8. Manual claim forms can be obtained from the website: **www.rsa.state.al.us/PEEHIP/peehip_contacts**.

9. A Participating Pharmacy must dispense a generic medication when one is available. Please read the section titled **HB171 Section 1** for additional information.

10. **Non-Medicare eligible retirees** and **Active** members requiring insulin and/or diabetic supplies:

    - Insulin, needles and syringes purchased on the same day in the same quantity will have one copay; otherwise, each has a separate copay. Insulin is a maintenance drug. The pharmacist must file for the insulin first and then file for the syringes. Syringes are covered at $0 copay.

    - Blood glucose test strips and lancets purchased on the same day in the same quantity will have one copay; otherwise, each has a separate copay. The pharmacists must file for the test strips first and then file for the lancets. Lancets are covered at $0 copay.

    - Glucose monitors always have a separate copay. Glucose monitors are limited to one per person each contract year.

    - Insulin pump and supplies are covered under Blue Cross Major Medical benefits and not under the pharmacy program.

    - The copay that applies depends on whether the monitor or supplies are generic, Preferred Brand or Non-Preferred Brand.

    - Blood glucose test strips, lancets and glucose monitors are the only diabetic supplies available through the Prescription Drug program.

    - Benefits for insulin, needles and syringes, blood glucose test strips, lancets and glucose monitors are only provided under the Prescription Drug benefits.

11. **Medicare eligible retirees** requiring insulin and/or diabetic supplies:

    - Insulin, needles and syringes purchased on the same day in the same quantity will have one copay; otherwise, each has a separate copay. Insulin is a maintenance drug.

    - Blood glucose test strips, lancets and glucose monitors are not covered under the Prescription Drug program for Medicare eligible retirees. These diabetic supplies are covered under Medicare Part B. In most cases, if you choose to use a Medicare participating pharmacy or supplier, the provider will bill Medicare and Medicare will pass your claim to Blue Cross and Blue Shield (not Express-Scripts) for the secondary processing. You will not pay anything at the point-of-sale after you have met your annual Medicare Part B deductible when you purchase from a Medicare participating provider.

## What is a Preferred Drug?

With so many prescription drugs available today, how can you be sure that you are receiving therapeutically safe and effective medication?

- An expert panel of physicians and pharmacists have developed and endorsed the Preferred Drug List.

- These drugs represent safe and cost-effective drug therapy.

- The Preferred Drug List is used primarily by physicians in selecting clinically appropriate and cost effective drugs for their patients.

- You can access the Preferred Drug List at the website: **www.express-scripts.com** or **www.rsa.state.al.us** and then choose PEEHIP.

## Making a Choice

1. When you purchase a prescription from a Participating Pharmacy, you will only be responsible for the copay.

2. The amount of the copay is determined by whether the drug you purchase is a brand-name prescription on the Preferred Drug List, another brand name drug not on the preferred drug list, or a generic.

3. Required copays: Generic-**lowest copay**; Preferred Brand Products-**standard copay**; all other brand products (not included on the Preferred Drug List)-**highest copay**.

4. Copay amounts for prescription drugs are determined according to your benefit plan design. Please check your group benefit materials for specific copay amounts and coverage information.

5. You will always receive the lowest copay when purchasing generics.

6. Some drugs do not have a generic equivalent, but many do. Simply ask your physician or pharmacist if a generic is available for your prescription.

## Step Therapy Program

The PEEHIP prescription drug program includes Step Therapy for certain medications. The Step Therapy program was implemented to keep the PEEHIP program sound and to keep premiums and co-payments at a reasonable and affordable level. The Step Therapy program applies to "new" prescriptions that have not been purchased in over 130 days. A prescription is considered "new" if the member or covered dependent has not filed and processed the prescription claim with Express Scripts in over 130 days.

Step Therapy is a program especially for people who take prescription drugs regularly to treat ongoing medical conditions such as arthritis/pain, heartburn, or high blood pressure. It is designed to:

- Provide safe and effective treatments for your good health,
- Make prescription more affordable, and
- Enable PEEHIP to continue to provide affordable prescription coverage while controlling rising costs.

Stop Therapy is organized in a series of "steps" with *your doctor* approving your medication every step of the way. It is developed under the guidance and direction of independent, licensed doctors, pharmacists and other medical experts. Together with Express Scripts, Inc. (ESI), they review the most current research on thousands of drugs tested and approved by the U.S. Food and Drug Administration (FDA) for safety and effectiveness.

***How does Step Therapy Work?***

**First Step**: Generic drugs are usually in the first step. These drugs are commonly prescribed, less expensive treatments that are safe and effective in treating many medical conditions. Your co-payment is usually the lowest with a first-step drug. It will be necessary for you to use the first-step drugs before the plan will pay for the second-step drugs.

**Second Step**: If your treatment path requires more medications, then the program moves you along to this step, which generally includes brand-name drugs. Brand-name drugs are usually more expensive than generics, so most have a higher co-payment.

When a prescription for a second-step drug is processed at your pharmacy for the first time, your pharmacist will receive a message indicating the PEEHIP plan uses Step Therapy. If you would rather not pay full price for your prescription drug, your doctor needs to give you a prescription for a first-step drug. Only your doctor can change your current prescription to a first-step drug covered by your program.

To receive a first-step drug:

**Ask your pharmacist to call your doctor** and request a new prescription

*or*

**Contact your doctor** to get a new prescription.

With Step Therapy, more expensive brand-name drugs are usually covered in a later step in the program if you have already tried the first-step drug. If your doctor decides you need a different drug for medical reasons before you have tried a first-step drug, then your doctor can call Express Scripts to request a "prior authorization." If the second-step drug is approved, you will pay a higher co-payment than for a first-step drug. If the drug is not approved, you will need to pay the full price for the drug. You can appeal the decision through the appeals process outlined in this book.

If you have medical reasons that prevent you from trying a first-step drug, your physician can contact Express Script to request a prior authorization by calling 800-347-5841. For other questions about the Step Therapy program, contact Express Scripts at 866-243-2125.

## Exclusions and Limitations

The following items are not eligible for coverage:

- Appetite Suppressants
- Contraceptive Devices
- Desoxyn/Dexedrine-for Weight Control Purposes
- Agents used to suppress appetite and control fat absorption (e.g. Xenical, Meridia)
- Experimental Drugs
- Over-the-Counter Drugs (OTC is not covered even if prescribed by a physician)
- Progesterone Suppositories-for PMS
- Replacement for Lost or Destroyed Drugs
- Topical Minoxidil
- Yocon
- Photo-aged skin products
- Hair growth agents
- Injectable cosmetics (e.g. Botox)
- Depigmentation products used for skin conditions requiring a bleaching agent
- Serums, toxoids and vaccines
- Legend homeopathic drugs
- OTC equivalents (Items available over the counter without a prescription even when prescribed by a physician (vitamins and food supplements)
- Non-Participating Pharmacies in Alabama are not covered
- Nicotine Gum
- Oral medications used to treat erectile dysfunction. Examples include, but are not limited to Viagra, Cialis, Levitra, and Yohimbine
- Prescription drugs and medicines are considered under "Prescription Drug Benefits" and are not eligible for coverage under Major Medical. Prescription drugs purchased from a Non-Participating Pharmacy in Alabama are not covered under any portion of the plan.

The following items have limited coverage:

- Contraceptive Drugs-oral contraceptives or other birth control methods are not covered except when they are prescribed by a physician for a medical condition and not for the purpose of birth control.
- Transcutaneous nicotine patches are limited to a three month supply in a lifetime when prescribed by a physician and dispensed by a licensed pharmacist.
- Growth hormones are not covered after age 18.
- Certain drugs have quantity level limits for a 34-day supply. Your pharmacist will advise if this is a requirement.
- Certain drugs require prior authorization to insure. Your pharmacist will advise if this is a requirement.
- Drug benefits for medically necessary fertility drugs are covered at a 50% copay for any infertility drug up to a lifetime maximum of $2,500 cost to the PEEHIP plan.

## HB171 Section 1

As a condition of participation in PEEHIP, a pharmacist shall dispense a generic equivalent medication to fill a prescription for a patient covered by PEEHIP when one is available unless the physician indicates in longhand writing on the prescription "medically necessary" or "dispense as written" or "do not substitute". The generic equivalent drug product dispensed shall be pharmaceutically and therapeutically equivalent and contain the same active ingredient or ingredients and shall be of the same dosage, form and strength.

## Individual Case Management

Unfortunately, some people suffer from catastrophic, long-term, and chronic illness or injury. If you have a catastrophic, long-term or chronic illness or injury, a Blue Cross Registered Nurse may assist you in accessing the most appropriate health care for your condition. The nurse case manager will work with you, your physician, and other health care professionals to design a treatment plan to best meet your health care needs. In order to implement the plan, you, your physician, and Blue Cross must agree to the terms of the plan. The program is voluntary to you and your physician. Under no circumstances are you required to work with a Blue Cross case management nurse. Benefits provided to you through Individual Case Management are subject to your benefit contract maximums. If you think that you may benefit from Individual Case Management, please call the Health Management division at (205) 733-7067 or 1-800-821-7231.

If you suffer from certain long-term, chronic, diseases or conditions you may qualify to participate in the Care Management Program. Care Management is designed for individuals whose long-term medical needs require disciplined compliance with a variety of medical and lifestyle requirements. If the manager of the Care Management Program determines from your claims data that you are a good candidate for Care Management, the manager will contact you and ask if you would like to participate. Participation in the program is completely voluntary. If you would like to obtain more information about the program, call Customer Service at 1-800-327-3994.

## Organ, Tissue and Bone Marrow/Cell Transplants

The organs and tissue for which there are benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas; (5) kidney; (6) heart-valve; (7) skin; (8) cornea; and (9) small bowel. Bone marrow transplants, which include stem cells and marrow to restore or make stronger the bone marrow function, are also included. The transplant must be performed in a hospital or other facility on the Blue Cross list of approved facilities for that type of transplant and it must have Blue Cross's advance written approval. When Blue Cross approves a facility for transplant services it is limited to the specific types of transplants stated. Donor organ costs are limited to search, removal, storage and the transporting of the organ and the removal team.

There are no transplant benefits for: (1) any artificial or mechanical devices; (2) organ or bone marrow transplants from animals; (3) donor costs available through other group coverage; (4) if any government funding is provided; (5) the recipient if not covered by this plan; (6) recipient or donor room, food, or transportation costs for which Blue Cross did not approve in writing; (7) a condition or disease for which a transplant is considered investigational; (8) transplants performed in a facility not on the Blue Cross approved list for that type or for which Blue Cross has not given written approval in advance.

## Infertility Services

Benefits for Medically Necessary infertility services are provided as follows:

- Artificial insemination and related services, including physician services, laboratory services, x-ray services, and ultrasound services

- Benefits for medications for infertility treatment are provided with a 50% copay up to a lifetime maximum cost of $2,500 for PEEHIP per member contract. Members will pay 100% of the medications after the $2,500 lifetime maximum is reached.

Benefits are NOT provided for Assisted Reproductive Technology (ART) which is any process taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction.

## Mastectomy and Mammograms

Women's Health and Cancer Rights Act Information

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema.

Treatment decisions are made by the attending physician and patient. Benefits for this treatment will be subject to the same calendar year deductibles and coinsurance provisions that apply for other medical and surgical benefits.

Benefits for Mammograms

Benefits for mammograms vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

- If the mammogram is performed in connection with the diagnosis or treatment of a medical condition, and if the provider properly files the claim with this information, Blue Cross will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays.

- If you are at high risk of developing breast cancer or you have a family history of breast

cancer - within the meaning of our medical guidelines - and if the provider properly files the claim with this information, Blue Cross will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays.

- In all other cases the claim will be subject to the routine mammogram benefit provisions and limits described elsewhere in this booklet.

# COORDINATION OF BENEFITS (COB)

COB is a provision designed to help manage the cost of health care by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary.

A primary plan is one whose benefits for a person's health care coverage must be determined first without taking the existence of any other plan into consideration.

A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan.

Which plan is primary is decided by the first rule below that applies (note, however, that if the other plan is Medicare the order of benefit determination is determined by the applicable Medicare secondary payer laws):

1. If the other plan has no COB provision, it is primary.

2. Employee/Dependent: The plan covering a patient as an employee, member, or subscriber (that is other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the employer, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

3. Dependent Child/Parents Not Separated or Divorced: If both plans cover the patient as a dependent child, the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary. If the other plan does not use this "birthday rule" the other plan's rule will be used.

4. Dependent Child/Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of divorced or separated parents, benefits are determined in this order:

   a. first, the plan of the parent with custody;

   b. second, the plan of the spouse of the parent with custody;

   c. third, the plan of the parent without custody; and

   d. last, the plan of the spouse of the parent without custody.

   If the divorced or separated parents have joint legal custody, benefits are determined as if the parents are not separated or divorced (see paragraph 3 above).

   If there is a court order that specifically states that one parent must provide for the childs health expenses or provide health insurance coverage for the child, benefits are determined in this order:

a. first, the plan of the court-ordered parent;

b. second, the plan of the spouse of the court-ordered parent;

c. third, the plan of the non-court-ordered parent; and,

d. last, the plan of the spouse of the non-court-ordered parent.

5. Active/Inactive Employee: When a patient is covered under one plan as an active employee and under another plan as a retired or inactive employee (e.g., a former employee receiving COBRA benefits), the plan which covers the patient as an active employee is primary over a plan which covers the patient as a laid-off or retired employee. This applies to the employee's dependents as well unless the dependents have other coverage due to their own current or former employment status.

6. Longer/Shorter Length of Coverage: If none of the above rules determine the order of payment, the plan covering the patient the longer time is primary.

If this plan is secondary, it will not pay more than if it had been primary.

### Non-Duplication of Benefits

If our records indicate the PEEHIP plan is secondary to another group plan, Blue Cross will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

When PEEHIP is the secondary plan, Blue Cross will first determine what benefits it would have paid had the PEEHIP plan been the only plan. Once the primary benefit has been determined, Blue Cross will subtract the payment made by the other plan from this amount. The resulting difference, if any, is the PEEHIP secondary benefit. The PEEHIP plan benefits plus the primary plan benefits will not exceed the amount that PEEHIP would have paid had PEEHIP been the only plan.

If a PEEHIP member or dependent had an insurance balance of $30 for an office visit after their primary plan pays, the PEEHIP plan would pay $10 as a secondary payer and the member would still be responsible for the $20 copayment under PEEHIP.

If the balance left after the primary plan pays is less than the applicable copayment for that service, then you pay the entire balance.

## SUBROGATION

### Right of Subrogation

If Blue Cross pays or provides any benefits for you under this plan, Blue Cross is subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits Blue Cross has paid or provided. That means that Blue Cross may use your right to recover money from that other person or organization.

### Right of Reimbursement

Besides the right of subrogation, Blue Cross has a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which Blue Cross has paid plan benefits. This means that you promise to repay Blue Cross from any money you recover the amount Blue Cross has paid or provided in plan benefits. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay PEEHIP. And, if you are paid by any person or company besides Blue Cross, including the person who injured you, that person's insurer, or your own insurer, you must repay PEEHIP. In these and all other cases, you must repay PEEHIP.

Blue Cross has the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you aren't made whole for your loss. This means that you promise to repay Blue Cross first even if the money you recover is for (or said to be for) a loss besides plan benefits, such as pain and suffering. It also means that you promise to repay Blue Cross first even if another person or company has paid for part of your loss. And it means that you promise to repay Blue Cross first even if the person who recovers the money is a minor. In these and all other cases, Blue Cross still has the right to first reimbursement or repayment out of any recovery you receive from any source.

### Right to Recovery

You agree to furnish Blue Cross promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with Blue Cross in protecting and obtaining their reimbursement and subrogation rights in accordance with this section.

You or your attorney will notify Blue Cross before filing any suit or settling any claim so as to enable Blue Cross to participate in the suit or settlement to protect and enforce our rights under this section. If you do notify Blue Cross so that they are able to and do recover the amount of their benefit payments for you, Blue Cross will share proportionately with you in any attorney's fees charged you by your attorney for obtaining the recovery. If you do not give Blue Cross that notice, their reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

You further agree not to allow Blue Cross reimbursement and subrogation rights under this plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, Blue Cross may suspend or terminate payment or provision of any further benefits for you under the plan.

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# CLAIMS AND APPEALS

The following explains the rules under your group health plan for filing claims and appeals.

Remember that you may always call the Customer Service Department for help if you have a question or problem that you would like Blue Cross to handle without an appeal. The phone number to reach our Customer Service Department is 1-800-327-3994.

## In General

Claims for benefits under the plan can be post-service, pre-service, or concurrent. This section of your booklet explains how Blue Cross processes these different types of claims and how you can appeal a partial or complete denial of a claim.

The claims and appeal procedures are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Even if your plan is not covered by ERISA, Blue Cross will process your claim according to ERISA's standards and provide you with the ERISA appeal rights that are discussed in this section of your booklet.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. Blue Cross has developed a form that you must use if you wish to designate an authorized representative. You can get the form by calling the Customer Service Department. You can also go to the Blue Cross Internet web site at **www.bcbsal.com** and ask that you be mailed a copy of the form. If a person is not properly designated as your authorized representative, Blue Cross will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

For urgent pre-service claims, Blue Cross will presume that your provider is your authorized representative unless you tell them otherwise in writing.

## Post-Service Claims

**What Constitutes a Claim:** For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), Blue Cross must receive a properly completed and filed claim from you or your provider.

In order for Blue Cross to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide Blue Cross with the data elements that they specify in advance. Most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call the Customer Service Department and ask for a claim form. Tell Blue Cross the type of service or supply for which you wish to file a claim (for example, hospital or physician), and they will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to Blue Cross at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by Blue Cross within 365 days after the service takes place to be eligible for benefits.

If Blue Cross receives a submission that does not qualify as a claim, they will notify you or your provider of the additional information needed. Once Blue Cross receives that information, they will process the submission as a claim.

**Processing of Claims:** Even if we have received all of the information that we need in order to treat a submission as a claim, from time to time we might need additional information in order to determine whether the claim is payable. The most common example of this is medical records that we may need in order to determine whether services or supplies were medically necessary. If we need this sort of additional information, we will ask you to furnish it to us, and we will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time.

Ordinarily, we will notify you of our decision within 30 days of the date on which your claim is filed. If it is necessary for us to ask for additional information, we will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

In some cases, we may ask for additional time to process your claim. If you do not wish to give us additional time, we will go ahead and process your claim based on the information we have. This may result in a denial of your claim.

**Who Gets Paid:** Some of the contracts we have with providers of services, such as hospitals, require us to pay benefits directly to the providers. With other claims we may choose whether to pay you or the provider. If you or the provider owes us money we may deduct the amount owed from the benefit paid. When we pay or deduct the amount owed from you or the provider, this completes our obligation to you under the plan. We need not honor an assignment of your claim to anyone. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.

## Pre-Service Claims

A pre-service claim is one in which you are required to obtain approval from Blue Cross before services or supplies are rendered. For example, you may be required to obtain precertification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the plan. Pre-service claims pertain only to the medical necessity of a service or supply. If we grant a pre-service claim, we are not telling you that the service or supply is, or will be, covered; we are only telling you that the service or supply meets our medical necessity guidelines. For example, we might precertify your inpatient hospital admission but later deny your claim because the admission related to a pre-existing condition or was for a service or supply that is excluded under the plan.

In order to file a pre-service claim you or your provider must call the Pre-Certification Department at 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free). You must tell us your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person we can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing. Written pre-service claims should be sent to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to Blue Cross during our regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to us within 48 hours of the admission and we certify the admission as both medically necessary and as an emergency admission. You are not required to precertify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review (CURP) hospital by a Preferred Medical Doctor (PMD Physician). If your plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from a Participating Chiropractor, Preferred Physical Therapist, or Preferred Occupational Therapist, your provider is responsible for initiating the precertification process for you. For home health care and hospice benefits (if covered by your plan), see the previous sections of this booklet for instructions on how to precertify treatment.

If you attempt to file a pre-service claim but fail to follow the procedures for doing so, Blue Cross will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). Blue Cross's notification may be oral, unless you ask for it in writing. Blue Cross will provide this notification to you only if (i) your attempt to submit a pre-service claim was received by a person or organizational unit of Blue Cross that is customarily responsible for handling benefit matters, and (ii), your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

**Urgent Pre-Service Claims:** Blue Cross will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician tells Blue Cross that your claim is urgent, Blue Cross will treat it as such.

If your claim is urgent, Blue Cross will notify you of their decision within 72 hours. If Blue Cross needs more information, Blue Cross will let you know within 24 hours of your claim. Blue Cross will tell you what further information they need. You will then have 48 hours to provide this information to Blue Cross. They will notify you of the decision within 48 hours after they receive the requested information. Blue Cross's response may be oral; if it is, Blue Cross will follow it up in writing within three days. If Blue Cross does not receive the information, your claim will be considered denied at the expiration of the 48-hour period given to you for furnishing the information to Blue Cross.

**Non-Urgent Pre-Service Claims:** If your claim is not urgent, Blue Cross will notify you of their decision within 15 days. If Blue Cross needs more information, they will let you know before the 15-day period expires. Blue Cross will tell you what further information they need. You will then have 90 days to provide this information to Blue Cross. In order to expedite the receipt of the information, Blue Cross may request it directly from your provider. If Blue Cross does this, they will send you a copy of the request. However, you will remain responsible for seeing that Blue Cross gets the information on time. Blue Cross will notify you of the decision within 15 days after they receive the requested information. If Blue Cross does not receive the information, your claim will be considered denied at the expiration of the 90-day period given to you for furnishing the information to Blue Cross.

**Courtesy Pre-Determinations:** For some procedures Blue Cross encourages, but does not require, you to contact the precertification department before you have the procedure. For example, if you or your physician thinks a procedure might be excluded as cosmetic, you can ask Blue Cross to determine beforehand whether the procedure is cosmetic or reconstructive. Blue Cross calls this type of review a courtesy pre-determination. If you ask for a courtesy pre-determination, Blue Cross will do their best to provide you with a timely response. If Blue Cross decides that they cannot provide you with a courtesy pre-determination (for example, Blue Cross cannot get the information needed to make an informed decision), Blue Cross will let you know. In either case, courtesy pre-determinations are not pre-service claims under the plan. When Blue Cross processes requests for courtesy pre-determinations, they are not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy pre-determination, you or your provider should call the Customer Service Department.

## Concurrent Care Determinations

**Determinations by Blue Cross to Limit or Reduce Previously Approved Care:** If Blue Cross previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and they later decide to limit or reduce the previously approved stay or course of treatment, Blue Cross will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules Blue Cross establishes for the filing of your appeal, such as time limits within which the appeal must be filed.

**Requests by You to Extend Previously Approved Care:** If a previously approved hospital stay or course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in writing or orally either directly to Blue Cross or through your treating physician or a hospital representative. The phone numbers to call in order to request an extension of care are as follows:

- For inpatient hospital care, call 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free).
- For Preferred Physical Therapy or Occupational Therapy (if covered by your plan) call 205-220-7202.
- For care from a Participating Chiropractor (if covered by your plan) call 205-220-6128.

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, Blue Cross will give you their decision within 24 hours of when your request is submitted. If your request is not made before this 24-hour time frame, and your request is urgent, Blue Cross will give you the determination within 72 hours. If your request is not urgent, Blue Cross will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above, as appropriate.

## Your Right To Information

You have the right, upon request, to receive copies of any documents that Blue Cross relied on in reaching their decision and any documents that Blue Cross submitted, considered, or generated by Blue Cross in the course of reaching their decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that Blue Cross may have relied upon in reaching their decision. If Blue Cross's decision was based on a medical or scientific determination (such as medical necessity), you may also request that Blue Cross provides you with a statement explaining the application of those medical and scientific principles to you. If Blue Cross obtained advice from a health care professional (regardless of whether they relied on that advice), you may request that Blue Cross give you the name of that person. Any request that you make for information under this paragraph must be in writing. Blue Cross will not charge you for any information that you request under this paragraph.

## Member Satisfaction

If you are dissatisfied with the handling of a claim or have any questions or complaints, you may do one or more of the following:

- You may call or write the Customer Service Department. The representatives will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received.
- You may file an appeal if you have received an adverse benefit determination.

## Appeals

**In General:** The rules in this section of the booklet allow you or your authorized representative to appeal any (hospital, physician, and prescription drug) adverse benefit determination. An adverse benefit determination includes any one or more of the following:

- any determination Blue Cross makes with respect to a post-service claim that results in your owing any money to your provider other than copayments you make, or are required to make, to your provider;
- Blue Cross's denial of a pre-service claim; or,
- an adverse concurrent care determination (for example, Blue Cross denies your request to extend previously approved care).

In all cases other than determinations by Blue Cross to limit or reduce previously approved care, you have 180 days following the adverse benefit determination within which to submit an appeal.

**How to Appeal Post-Service Adverse Benefit Determinations:** If you wish to file an appeal of an adverse benefit determination relating to a post-service claim, it is recommended that you use a form that has been developed for this purpose. The form will help you provide the information that is needed to consider your appeal. To get the form, you may call the Customer Service Department at 1-800-327-3994. You may also go to the Internet web site at **www.bcbsal.com**. Once there, you may ask for a copy of the form.

If you choose not to use the appeal form, you may send a letter to Blue Cross. Your letter must contain at least the following information:

- the patient's name;
- the patient's contract number;
- sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available) (the best way to satisfy this requirement is to include a copy of your Claims Report with your appeal); and,
- a statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Customer Service Appeals
P. O. Box 12185
Birmingham, Alabama 35202-2185

Please note that if you call or write Blue Cross without following the rules just described for filing an appeal, Blue Cross will not treat your inquiry as an appeal. Blue Cross will do everything they can to resolve your questions or concerns.

**How to Appeal Pre-Service Adverse Benefit Determinations:** You may appeal an adverse benefit determination relating to a pre-service claim in writing or over the phone.

If you appeal over the phone, you should call the appropriate phone number listed below:

- For inpatient hospital care and admissions, call 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll-free).
- For Preferred Physical Therapy or Occupational Therapy (if covered by your plan) call 205-220-7202.
- For care from a Participating Chiropractor (if covered by your plan) call 205-220-6128.

If you appeal in writing, you should send your letter to the appropriate address listed below:

- For inpatient hospital care and admissions:

  Blue Cross and Blue Shield of Alabama
  Attention: Health Management – Appeals
  P. O. Box 2504
  Birmingham, Alabama 35201-2504

  and

- For Preferred Physical Therapy, Occupational Therapy, or care from a Participating Chiropractor (when covered by your plan):

Blue Cross and Blue Shield of Alabama
Attention: Health Management – Appeals
P. O. Box 362025
Birmingham, Alabama 35236

Your written appeal should provide us with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

Please note that if you call or write Blue Cross without following the rules just described for filing an appeal, Blue Cross will not treat your inquiry as an appeal. Blue Cross will do everything they can to resolve your questions or concerns.

**Conduct Of The Appeal:** Blue Cross will assign your appeal to one or more persons within the organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires Blue Cross to make a medical judgment (such as whether services or supplies are medically necessary), Blue Cross will consult a health care professional who has appropriate expertise. If Blue Cross consulted a health care professional during their initial decision, Blue Cross will not consult that same person or a subordinate of that person during the consideration of your appeal.

If Blue Cross needs more information, Blue Cross will ask you to provide it to them. In some cases Blue Cross may ask your provider to furnish that information directly to them. If Blue Cross does this, they will send you a copy of the request. However, you will remain responsible for seeing that Blue Cross gets the information. If Blue Cross does not get the information, it may be necessary for Blue Cross to deny your appeal.

Blue Cross will consider your appeal fully and fairly.

**Time Limits For Blue Cross Consideration Of Your Appeal:** If your appeal arises from Blue Cross's denial of a post-service claim, Blue Cross will notify you of the decision within 60 days of the date on which you filed your appeal.

If your appeal arises from the denial of a pre-service claim, and if your claim is urgent, Blue Cross will consider your appeal and notify you of the decision within 72 hours. If your pre-service claim is not urgent, Blue Cross will give you a response within 30 days.

If your appeal arises out of a determination by Blue Cross to limit or reduce a hospital stay or course of treatment that was previously approved for a period of time or number of treatments, (see Concurrent Care Determinations above), Blue Cross will make a decision on your appeal as soon as possible, but in any event before Blue Cross imposes the limit or reduction.

If your appeal relates to Blue Cross's decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations above), Blue Cross will make a decision on your appeal within 72 hours (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

In some cases, Blue Cross may ask for additional time to process your appeal. If you do not wish to give Blue Cross additional time, they will go ahead and decide your appeal based on the information they have. This may result in a denial of your appeal.

**If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies:** If you have filed an appeal and are dissatisfied with the response, you may do one or more of the following:

- you may ask our Customer Service Department for further help;
- you may file a voluntary appeal (discussed below).

**Voluntary Appeals:** If Blue Cross has given you their appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination, you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal.

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), Blue Cross will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. Blue Cross will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, Blue Cross will not impose any fees or costs on you as part of your voluntary appeal.

You may ask Blue Cross to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

# GENERAL INFORMATION

## Delegation of Discretionary Authority to Blue Cross

PEEHIP has delegated to Blue Cross the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with our provision of administrative services under the plan. Whenever Blue Cross makes reasonable determinations that are neither arbitrary nor capricious in the administration of the plan, those determinations will be final and binding on you, subject only to your right of review under the plan and thereafter to judicial review to determine whether the determination was arbitrary or capricious.

## Notice

Blue Cross gives you notice when they mail it or send it electronically to you or your group at the latest address they have. You and your group are assumed to receive notice three days after Blue Cross mails it. Your group is your agent to receive notices from Blue Cross about the plan. The group is responsible for giving you all notices from Blue Cross. Blue Cross is not responsible if your group fails to do so. Mail notices to Blue Cross at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858, with your full name and contract number. Blue Cross gets notice when it arrives at this address.

## Correcting Payments

While Blue Cross tries to pay all claims quickly and correctly, they do make mistakes. If Blue Cross pays you or a provider in error, the payee must repay Blue Cross. If he or she does not, Blue Cross may deduct the amount paid in error from any future amount paid to you or the provider. If Blue Cross deducts it from an amount paid to you, it will show in your Claim Report.

## Responsibility for Providers

Blue Cross is not responsible for what providers do or fail to do. If they refuse to treat you or give you poor or dangerous care, Blue Cross cannot be responsible. Blue Cross does not do anything to enable them to treat you.

## Misrepresentation

If you make any material misrepresentation in applying for coverage, when the PEEHIP office learns of this, the PEEHIP office may terminate your coverage back to your effective date. The PEEHIP office need not even refund any payment for your coverage.

## Multiple Coverage

If you are covered both by this contract and by a non-group contract issued by Blue Cross, you will be entitled to benefits only under the one that provides the most coverage for you.

## Termination of Benefits and Termination of the Plan

1. Blue Cross's obligation to provide benefits under the Plan may be terminated at any time by either PEEHIP or Blue Cross by giving 30 days notice in writing to the other.

2. If PEEHIP fails to pay the amount due within 30 days after it becomes due, Blue Cross's obligation to provide benefits under the Plan will terminate automatically and without notice to you or PEEHIP as of the date due for the payment.

3. The Plan Sponsor may terminate the Plan at any time through action by its authorized officers. In the event of termination of the Plan, all benefit payments will cease as of the effective date of termination, regardless of whether notice of the termination has been provided to you by PEEHIP or Blue Cross.

## Changes in Plan

1. Any or all of the provisions of this plan may be amended by the Plan Sponsor at any time and from time to time, by an instrument in writing.

2. No representative or employee of Blue Cross is authorized to amend or vary the terms and conditions of this plan or to make any agreement or promise not specifically contained herein or to waive any provision hereof.

## Out-of-Area Co-Pay and Co-Insurance

When you obtain health care services through the BlueCard Program outside of the Alabama service area, the amount you pay for covered services is calculated on the **lower** of:

1. The billed charges for your covered services, or

2. The negotiated price that the on-site Blue Cross and/or Blue Shield plan ("Host Plan") passes on to Blue Cross.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Plan. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Plan to use a basis for calculating your payment for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate payment calculation methods that differ from the usual BlueCard method noted above in paragraph one of

this section or require a surcharge, Blue Cross would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

# HEALTH BENEFIT EXCLUSIONS

Benefits are not provided for the following:

1. Services or expenses Blue Cross determines are not medically necessary.

2. Services, care, or treatment you receive after the date your coverage ends. This means, for example, that if you are in the hospital when your coverage ends, Blue Cross will not pay for any more hospital days. Blue Cross does not insure against any condition such as pregnancy or injury. Blue Cross and PEEHIP provide benefits only for services and expenses furnished while this plan is in effect.

3. Services or expenses for cosmetic surgery. "Cosmetic surgery" is any surgery done primarily to improve or change the way one appears. "Reconstructive surgery" is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit; cosmetic surgery is not. (See the section, Women's Health and Cancer Rights Act, for exceptions.) Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.

    a. Please contact Blue Cross prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to Blue Cross's satisfaction that surgery is reconstructive and not cosmetic. You must show Blue Cross history and physical exams, visual fields measures and photographs before and after surgery.

    b. Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and many sinus infections. To correct this they have a septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance but reconstructive if done because your eyelids kept you from seeing very well.

4. Services or expenses to care for, treat, fill, extract, remove or replace teeth or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or "dead" teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded. It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are plan benefits. Braces on the teeth are excluded for any purpose, even to prepare a person with a cleft palate for surgery on the bones of the jaw. With the exception of braces, which are never covered under the medical plan, this exclusion does not apply to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under Other Covered Services.

5. Dental implants into, across, or just above the bone and related appliances. Services or expenses to prepare the mouth for dental implants such as those to increase the upper and lower jaws or their borders, sinus lift process, guided tissue regrowth or any other surgery, bone grafts, hydroxyapatite and similar materials. These services, supplies or expenses, even if medically or dentally necessary, are not covered under the medical plan even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident.

6. Services or expenses rendered for any disease, injury or condition arising out of and in the course of employment for which benefits and/or compensation are available in whole or in part under the provisions of any workers' compensation or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the employer. It applies whether the law provides for hospital or medical services as such. It applies whether the provider of those services was authorized as required by the law. Finally, it applies whether your employer has insurance coverage for benefits under the law.

7. Services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other governmental agency that provides or pays for care, through insurance or any other means. This applies even if the law does not cover all your expenses.

8. Services or supplies to the extent that a member is, or would be, entitled to reimbursement under Medicare, regardless of whether the member properly and timely applied for, or submitted claims to, Medicare, except as otherwise required by federal law.

9. Routine well child care and routine immunizations except as provided in PPO benefits.

10. Routine physical examinations except as provided in PPO benefits.

11. Services or expenses for custodial care. Care is "custodial" when its primary purpose is to provide room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a physician for a person who is mentally or physically disabled.

12. Investigational treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including services that are part of a clinical trial.

13. Services or expenses for routine foot care such as removal of corns or calluses or the trimming of nails (except mycotic nails).

14. Hospital admissions in whole or in part when the patient primarily receives services to rehabilitate such as physical therapy, speech therapy, or occupational therapy. However, benefits are provided for inpatient hospital admissions for rehabilitation for up to 60 days for each member while covered under the PEEHIP plan when approved in advance by Blue Cross.

15. Services and expenses provided to a hospital patient which could have been provided on an outpatient basis, given the patient's condition and the services provided. Benefits for those services will apply as though the services were provided on an outpatient basis. Examples are hospital stays primarily for diagnosis, diagnostic study, medical observation, rehabilitation, physical therapy and hydrotherapy.

16. Services or expenses for, or related to, sexual dysfunctions or inadequacies not related to organic disease or which are related to surgical sex transformations.

17. Services for or related to pregnancy, including the six-week period after delivery, of any dependent other than the employee's wife.

18. Services or expenses for an accident or illness resulting from war, or any act of war, declared or undeclared, or from riot or civil commotion.

19. Services or expenses for treatment of injury sustained in the commission of a crime or for treatment while confined in a prison, jail, or other penal institution.

20. Services or expenses for which a claim is not properly submitted to Blue Cross.

21. Services or expenses for treatment of any condition including, but not limited to, obesity, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion does not apply to surgery for morbid obesity if medically necessary and in compliance with guidelines of the Claims Administrator. Benefits will only be provided for one surgical procedure for obesity (morbid) in a lifetime. Benefits will not be provided for subsequent surgery for complications related to a covered surgical procedure for obesity (morbid) if the complications arise from non-compliance with medical recommendations regarding patient activity and lifestyle following the procedure.

22. Services or expenses which you are not legally obligated to pay, or for which no charge would be made if you had no health coverage.

23. Services or expenses for or related to organ, tissue or cell transplantations except specifically as allowed by this plan.

24. Dental treatment for or related to temporomandibular joint (TMJ) disorders. This includes Phase II, according to the guidelines approved by the Academy of Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth or a combination of these treatments.

25. Services or expenses for or related to Assisted Reproductive Technology (ART). ART is any process of taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction. Examples of ART are in vitro fertilization and gamete intrafallopian transfer.

26. Eyeglasses or contact lenses or related examination or fittings. One pair of eyeglasses, contact lenses or one pair of each will be covered under Other Covered Services if they replace the lens of the eye after eye surgery or injury or defect.

27. Services or expenses for personal hygiene, comfort or convenience items such as air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles according to preset rules, and related services performed during the same therapy session are also excluded.

28. Services or expenses for occupational therapy (except for hand therapy as stated previously in Other Covered Services), recreational and educational therapy.

29. Services or expenses for eye exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including radial keratotomy.

30. Services or expenses for acupuncture, biofeedback and other forms of self-care or self-help training.

31. Hearing aids or examinations or fittings for them.

32. Services or expenses of a hospital stay, except one for an emergency, unless Blue Cross certifies it before your admission. Services or expenses of a hospital stay for an emergency if Blue Cross is not notified within 48 hours, or on the next business day after your admission, or if Blue Cross determines that the admission was not medically necessary.

33. Services or expenses of private duty nurses.

34. Services, care, treatment, or supplies furnished by a provider that is not recognized by Blue Cross as an approved provider for the services rendered as explained more fully in paragraph 5. under "Benefit Conditions."

35. Services or expenses any provider rendered to a member who is related to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed physical therapist.

36. Services or expenses of any kind for nicotine addiction such as smoking cessation treatment. However, benefits are provided for transcutaneous nicotine patches by ESI.

37. Travel, even if prescribed by your physician.

38. Inpatient care or treatment for mental and nervous disorders or disease (including alcoholism and drug addiction) is excluded under Major Medical Benefits once the basic hospital days are exhausted.

39. Services or expenses of any kind provided by a Non-Participating Hospital located in Alabama for any benefits under this plan, except for inpatient and outpatient hospital benefits in case of accidental injury and for outpatient hospital service benefits in case of accidental injury, as more fully described under "Inpatient Hospital Benefits" and "Outpatient Hospital Benefits."

40. Services or expenses for a claim we have not received within 365 days after services were rendered or expenses incurred.

41. Services or expenses for physical therapy which does not require a licensed physical therapist, given the level of simplicity and the patient's condition, will not further restore or improve the patient's bodily functions, or is not reasonable as to number, frequency or duration.

42. Services or expenses in any federal hospital or facility except as provided by federal law.

43. Services or expenses for sanitarium care, convalescent care, or rest care.

44. Oral contraceptives or other birth control methods for the purpose of birth control.

45. Non-PPO inpatient care or treatment for mental and nervous disorders or disease (including alcoholism and drug addiction) other than for acute care or treatment. Domiciliary or custodial care is not covered.

46. X-ray or laboratory services performed for a hospital or physician by the Alabama State Health Department.

47. Prescription drugs and medicines are administered by Express-Scripts, Inc. (ESI) and are not eligible for coverage under Major Medical.

48. Services provided through teleconsultation.

49. Services provided by Substance Abuse Facilities including Substance Abuse Residential Facilities, except for PEEHIP PPO Facilities.

50. Services provided by Psychiatric Specialty Hospitals which do not participate with nor are considered members of any Blue Cross and/or Blue Shield Plan, except for PEEHIP PPO Facilities.

51. Services and expenses rendered by a Non-Preferred Home Health Care or Non-Preferred Hospice provider in Alabama.

52. Anesthesia services or supplies, or both, by local infiltration.

53. Services provided by a Non-Participating Renal Dialysis Facility in Alabama.

54. Insulin, needles and syringes, blood glucose strips, lancets and glucose monitors. This exclusion does not apply if Medicare is your primary payer.

55. Hospital admissions and expenses for dental procedures. Benefits for dental admissions, including anesthesia services, may be covered when meets Blue Cross medical criteria. Predeterminations before the service is rendered will be required to determine medical necessity. Services provided to any child five years of age or less will not require medical review. Benefits will continue to be provided for medical services not related to the dental services that occur during the same hospital admission.

56. Services or expenses for elective abortions.

57. Services or expenses for reversal of elective sterilization.

# DEFINITIONS

**Accidental Injury:** A traumatic injury to you caused solely by an accident.

**Allowed Amount:**Benefit payments for covered services are based on the amount of the provider's charge that we recognize for payment of benefits. This amount is limited to the lesser of the provider's charge for care or the amount of that charge that is determined by us to be allowable depending on the type of provider utilized and the state in which services are rendered, as described below:

1) **Preferred Providers:**Blue Cross and Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the preferred provider normally accepts this rate (subject to any applicable copays, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered services or care. The negotiated price applies only to services that are covered under the Plan and also covered under the contract that has been signed with the preferred provider. Please be aware that not all participating or contracting providers are preferred providers. Each local Blue Cross and/or Blue Shield plan determines which of its participating or contracting providers will be considered preferred providers.

2) **Non-Preferred Providers:** The Allowed Amount for care for non-preferred providers or for services or supplies not included in a preferred provider's contract is normally determined by the Blue Cross and/or Blue Shield plan where services are rendered. This amount may be based on the negotiated rate payable to preferred providers, or may be based on the average or anticipated charge or discount for care in the area or state, or for care from that particular type of provider. When the local Blue Cross and/or Blue Shield plan does not provide us with appropriate pricing data or when we are determining the Allowed Amount for services or supplies by a non-preferred provider (or for services and supplies not included in the contract with the provider), Blue Cross and Blue Shield of Alabama determines the Allowed Amount using

historical data and information from various sources such as, but not limited to:

- The charge for the same or a similar service;
- The relative complexity of the service;
- The preferred provider allowance for the same or a similar service;
- The average expected or estimated provider discount for the type of provider in the service area, as reported by the Blue Cross and Blue Shield Association from time to time;
- Applicable state health care factors;
- The rate of inflation using a recognized measure; and,
- Other reasonable limits, as required with respect to outpatient prescription drug costs.

Non-preferred providers include providers that have not signed a contract with the Blue Cross and/or Blue Shield plan where services are rendered as well as participating or contracting providers who have not been designated by the local Blue Cross and/or Blue Shield plan as preferred providers.

In this situation the provider may bill the member for charges in excess of the Allowed Amount. The Allowed Amount will not exceed the amount of the provider's charge.

**Application:** The subscriber's original application form and any written supplemental application accepted by PEEHIP.

**Assisted Reproductive Technology (ART):** Any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer.

**Blue Cross:** Blue Cross and Blue Shield of Alabama.

**BlueCard Program:** An arrangement among Blue Cross Plans by which a member of one Blue Cross Plan receives benefits available through another Blue Cross Plan located in the area where services occur.

**Certification of Medical Necessity:** The written results of our review using recognized medical criteria to determine whether a member requires treatment in the hospital before he is admitted, or within 48 hours of the next business day after the admission in the case of emergency admissions. Certification of medical necessity means only that a hospital admission is medically necessary to treat your condition. Certification of medical necessity does not mean that your group has paid us all monies due for you. Certification of medical necessity does not consider whether your admission is excluded by this plan.

**Chiropractic Fee Schedule:** The schedule of chiropractic procedures and corresponding fee amounts for Participating Chiropractic Benefits.

**Concurrent Utilization Review Program (CURP):** A program designed to promote the most efficient and effective use of health care resources while utilizing cost-effective methods to administer benefits.

**Contract:** The Group Health Benefits contract between PEEHIP and Blue Cross and Blue Shield of Alabama. The contract is made up of (1) PEEHIP's Group Application for the contract; (2) this Summary Plan Description; and (3) any written change to this Summary Plan Description. Your contract number is listed on your ID card.

**Contract Effective Date:** The date the Group Health Benefits contract becomes effective; the same date we accept the Group Application.

**Cosmetic Surgery:** Any surgery done primarily to improve or change the way one appears, cosmetic surgery does not primarily improve the way the body works or correct deformities resulting from disease, trauma or birth defect. For important information on cosmetic surgery, see the "Exclusions" section.

**Custodial Care:** Care primarily to provide room and board for a person who is mentally or physically disabled.

**Dependent:** See the explanation in the "Eligibility and Enrollment" section.

**Durable Medical Equipment:** Equipment we approve as medically necessary to diagnose or treat an illness or injury or to prevent a condition from becoming worse. To be durable medical equipment an item must be made to withstand repeated use, be for a medical purpose rather than for comfort or convenience, be useful only if you are sick or injured, and be related to your condition and prescribed by your physician to use in your home.

**Effective Date:** The date on which the coverage of each individual subscriber and dependent begins as listed in Blue Cross's records.

**Elective Abortion:** An abortion performed for reasons other than the compromised physicial health of the mother, severe chromosomal or fetal deformity, or conception due to incest or rape.

**Eligible Person:** Any employee or member of the group or other person who meets the eligibility standards of their plan and is designated as eligible to us by the group.

**Employee:** The Public Education member whose application for coverage under the contract is made and accepted by PEEHIP.

**Family Coverage:** Coverage for a subscriber and one or more dependents.

**Fee Schedule:** The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Doctor program and other Preferred Provider programs as applicable.

**Group:** PEEHIP which contracts with Blue Cross and through which you have coverage.

**Home Health Care Agency:** A Preferred or a Non-Preferred Home Health Care Agency.

**Hospice:** A Preferred or a Non-Preferred Hospice.

**Hospital:** A Participating or a Non-Participating Hospital as defined in this plan.

**Individual Case Management:** Benefits which are an alternative to more expensive covered benefits. They provide the patient with the best environment for recovery and in the most cost-effective setting. Also known as "Comprehensive Managed Care" and "Care Management."

**Inpatient:** A registered bed patient in a hospital.

**Investigational:** Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either Blue Cross does not recognize as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, Blue Cross develops written criteria (called medical criteria) concerning services or supplies that they

consider to be investigational. Blue Cross bases the criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. Blue Cross puts these medical criteria in policies that Blue Cross makes available to the medical community and their members. Blue Cross does this so that you and your providers will know in advance, when possible, what they will pay for. If a service or supply is considered investigational according to one of Blue Cross's published medical criteria policies, Blue Cross will not pay for it. If the investigational nature of a service or supply is not addressed by one of Blue Cross's published medical criteria policies, Blue Cross will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when Blue Cross makes determinations about the investigational nature of a service or supply they are making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by attending physician and other medical providers.

**Medical Emergency:** A medical condition that occurs suddenly and without warning with symptoms which are so acute and severe as to require immediate medical attention to prevent permanent damage to the health, other serious medical results, serious impairment to bodily function, or serious and permanent lack of function of any bodily organ or part.

**Medically Necessary or Medical Necessity:** Blue Cross uses these terms to help determine whether a particular service or supply will be covered. When possible, Blue Cross develops written criteria (called medical criteria) that is vital to determine medical necessity. Blue Cross bases this criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. Blue Cross puts these medical criteria in policies that are made available to the medical community and Blue Cross members. Blue Cross does this so that you and your providers will know in advance, when possible, what Blue Cross will pay for. If a service or supply is not medically necessary according to one of Blue Cross's published medical criteria policies, Blue Cross will not pay for it. If a service or supply is not addressed by one of Blue Cross's published medical criteria policies, Blue Cross will consider it to be medically necessary only if it is determined to be:

- appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
- provided for the diagnosis or direct care and treatment of your medical condition;
- in accordance with standards of good medical practice accepted by the organized medical community;
- not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- not "investigational;" and,
- performed in the least costly setting, method, or manner, or with the least costly supplies,

required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

It is important for you to remember that when Blue Cross makes medical necessity determinations, they are making them solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

**Medicare:** The Health Insurance for the Aged Program under Title XVIII of the Social Security Act (P.L. 89-97) as amended.

**Member:** A subscriber or eligible dependent who has coverage under the contract. The term member also refers to a former dependent or subscriber who was not terminated for gross misconduct, who is eligible for and covered under COBRA.

**Mental and Nervous Disorders:** These are mental disorders, mental illness, psychiatric illness, mental conditions and psychiatric conditions. These disorders, illnesses and conditions are considered mental and nervous disorders whether they are of organic, biological, chemical, or genetic origin. They are considered mental and nervous disorders however they are caused, based or brought on. Mental and nervous disorders include, but are not limited to, psychoses, neuroses, schizophrenic-affective disorders, personality disorders, and psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or related system of hormones controlled by nerves. They are intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

**Mental Health Preferred Provider Organization:** Those providers who have contracted with Public Education Employees' Health Insurance Board (PEEHIB) through the Certified Community Mental Health Center (CMHC) to provide certain mental health and substance abuse services referred to in Exhibit I of the contract between PEEHIB and CMHC.

**Non-Participating Chiropractor:** A Doctor of Chiropractic (D.C.) who is not a Participating Chiropractor.

**Non-Participating Hospital:** Any hospital (other than a Participating Hospital) that has been approved by the Alabama Hospital Association or the American Hospital Association as a "general" hospital or meets the requirements of the American Hospital Association for registration or classification as a "general medical and surgical" hospital. "General" hospitals do not include those that are classified or could be classified under standards of the American Hospital Association as "special" hospitals. Examples of these "special" hospitals are those classified for psychiatric, alcoholism and other chemical dependency, rehabilitation, mental retardation, chronic disease or any other specialty. "General" hospitals also do not include facilities primarily for convalescent care or rest or for the aged, school or college infirmaries, sanatoria, or nursing homes.

**Non-Participating Pharmacy:** Any pharmacy which is not a Participating Pharmacy.

**Non-PPO Provider:** Any provider which is not a PPO Provider with any Blue Cross and/or Blue Shield Plan.

**Non-Preferred Drugs:** Any brand name drug that is not a Preferred Drug.

**Non-Preferred Home Health Care Agency:** Any home health care agency which is not a Preferred Home Health Care Agency.

**Non-Preferred Hospice:** Any hospice which is not a Preferred Hospice.

**Open Enrollment:** The time period each year during which eligible Employees may apply for coverage for themselves and their dependents.

**PPO:** Preferred Provider Organization.

**PPO Allowance:** The amount that any Blue Cross and/or Blue Shield Plan has agreed to pay its PPO Provider for plan benefits.

**PPO Fee Schedule:** The schedule of medical and surgical procedures and the fee amounts for those procedures under the Preferred Medical Doctor program and other Preferred Provider programs as applicable.

**PPO Hospital, PPO Physician, PPO Provider, or Preferred Provider:** Any hospital, physician, or provider with which any Blue Cross and/or Blue Shield Plan has a PPO contract for the furnishing of health care services.

**Participating Ambulatory Surgical Facility:** Any facility with which Blue Cross and Blue Shield of Alabama has a Participating Ambulatory Surgical Facility contract for furnishing health care services.

**Participating Chiropractor:** A Doctor of Chiropractic (D.C.) who has an agreement with Blue Cross.

**Participating Hospital:** Any hospital with which Blue Cross and/or Blue Shield Plan has a contract for furnishing health care services.

**Participating Pharmacy:** Any pharmacy with which Express-Scripts, Inc. (ESI) has a contract for dispensing prescription drugs.

**Participating Renal Dialysis Facility:** Any freestanding hemodialysis facility with which Blue Cross and Blue Shield of Alabama has a contract for furnishing health care services.

**Physician:** One of the following when licensed and acting within the scope of that license at the time and place you are treated or receive services: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S), Doctor of Medical Dentistry (D.M.D.), Doctor of Chiropractic (D.C.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), and Psychologists who are licensed by the state in which they practice (Ph.D., Psy.D. or Ed.D.), as defined in Section 27-1-18 of the Alabama Code.

**Plan:** This Summary Plan Description (SPD) describing the benefits of your Public Education Employee's Health Insurance Plan Benefits.

**Preadmission Certification and Postadmission Review:** The procedures used to determine whether a member requires treatment as a hospital inpatient prior to a member's admission, or within 48 hours or the next business day after the admission in the case of an emergency admission, based upon medically recognized criteria.

**Preferred Care:** A program whereby providers have agreements with Blue Cross to furnish certain medically necessary services and supplies according to an agreed upon fee schedule for medical and surgical procedures, certain services and supplies to members entitled to benefits under the Preferred Care Program.

**Preferred Drugs:** Brand name drugs that combine effectiveness and cost efficiency, as determined by an expert group of physicians and pharmacists for Express Scripts, Inc.

**Preferred Home Health Care Agency:** Any home health care agency inside or outside of Alabama with which Blue Cross has a contract.

**Preferred Home Health Care Fee Schedule:** The schedule of procedures and the fee amounts listed in the Preferred Home Health Care Fee Schedule or the amount of the Preferred provider's actual charge, whichever is less for Preferred Home Health Care Benefits.

**Preferred Hospice:** Any hospice inside or outside of Alabama with which Blue Cross has a contract.

**Preferred Medical Doctor or Preferred Physician:** A physician who has an agreement with Blue Cross to provide surgical and medical services to members entitled to benefits under the PPO Program or another Preferred Care Program through a contract with Blue Cross.

**Preferred Provider Organization (PPO):** Hospitals, physicians, or other providers who have agreements with any Blue Cross and Blue Shield Plan or PEEHIP to provide surgical and medical services to members entitled to plan benefits under the PPO Program.

**Pregnancy:** The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body-usually, but not always, in the uterus-and lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

**Private Duty Nursing:** Nursing care provided in the patient's home by a licensed professional nurse (R.N.) or a licensed practical nurse (L.P.N.) who does not reside in the patient's home and is not related to the patient by blood or marriage.

**Public Education Employees' Health Insurance Board:** The Board charged with the administration of a health insurance plan for Public Education employees and their dependents.

**Public Education Employees' Health Insurance Plan (PEEHIP):** The health insurance plan for Public Education employees and their dependents.

**Retired Employee:** A former employee who receives a monthly benefit from the Teachers' Retirement System of Alabama. This excludes retired members of the Teachers' Retirement System who were State employees immediately prior to retirement.

**Subscriber:** The employee whose application for coverage under the contract is made and accepted by Blue Cross and PEEHIP.

**Teleconsultation:** Consultation, evaluation, and management services provided to patients via telecommunication systems without personal face-to-face interaction between the patient and healthcare provider.

**Total Disability:** The complete inability of an Active Employee to perform any and every duty pertaining to his occupation or employment, or the complete inability of a Retired Employee or a Dependent to perform the normal activities of a person of like age and sex.

**We, Us, Our:** Blue Cross and Blue Shield of Alabama.

**You, Your:** The subscriber or member as shown by context.

# PROVISION FOR MEDICARE-ELIGIBLES

## Active Employees

The Public Education Employees' Health Insurance Plan is required by the Age Discrimination in Employment Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982, to offer its active employees over age 65 coverage under its group health plan under the same condition as any employee under age 65. As a result of an accompanying amendment to the Social Security Act, Medicare is secondary to benefits payable under an employer-sponsored health insurance plan for employees over age 65 and their spouses over age 65. If the service is also covered by Medicare, the claim can be submitted to Medicare which may pay all or a portion of the unpaid balance of the claim subject to Medicare limitations.

As a result of these changes, PEEHIP does not provide an active member or his/her spouse with benefits which supplement Medicare. The member has the right to elect coverage under the Public Education Employees' Health Insurance Plan on the same basis as any other employee.

If a member chooses to be covered under the Public Education Employees' Health Insurance Plan, the plan will be the primary payer for those items and services covered by Medicare. (Note that Medicare covers hospitalization, post-hospital nursing home care, home health services.) This means that the plan will pay the covered claims and those of the member's Medicare-eligible spouse first, up to the limits contained in the plan, and Medicare may pay all or a portion of the unpaid balance of the claims, if any, subject to Medicare limitations. If the member's spouse is not eligible for Medicare, the Plan will be the sole source of payment of the spouse's claims.

Since the Public Education Employees' Health Insurance Plan also covers items and services not covered by Medicare, the Plan will be the sole source of payment of medical claims for these services.

Because of the cost of Medicare Part B, a member age 65 or older or Medicare eligible spouse of an active member, may decide to defer enrolling for Part B until the member actually reaches retirement, at which point Medicare will become the primary payer and the member and/or spouse will need to enroll in Medicare Part B effective the date of retirement. However, a member and his/her Medicare-eligible spouse can enroll for Medicare Part B only during the month he/she or his/her spouse reaches age 65 or during January, February and March of each year, or when you or your spouse retire. The Social Security Administration handles Medicare enrollments.

If you have questions about when to enroll in Medicare Part B, you should contact the Social Security Administration at 1-800-772-1213. **A Medicare-eligible retiree and/or spouse must have both Medicare Part A and B to have adequate coverage with PEEHIP. If you do not have Part B, PEEHIP will only pay 20% of the Medicare allowable fee (subject to a $20 copay on office visits, emergency room visits and outpatient consultations) as if you had Part B.**

## If I Work After Age 65 or Become Eligible for Medicare, Am I Still Covered?

If you continue to be actively employed when you are age 65 or older, you and your spouse will continue to be covered for the same benefits available to employees under age 65. In this case, your group benefits plan will pay all eligible expenses first. If you are enrolled in Medicare, Medicare will pay for Medicare-eligible expenses, if any, not paid by the group benefits plan.

If both you and your spouse are over age 65, you may elect to disenroll completely from the plan and purchase a Medicare Supplement contract. This means that you will have no benefits under the plan. In addition, the employer is prohibited by law from purchasing your Medicare Supplement contract for you or reimbursing you for any portion of the cost of the contract.

*Other Medicare Rules*

Disabled Individuals: If you or your spouse is eligible for Medicare due to disability and is also covered under the plan by virtue of your current employment status with the employer, the plan will be primary and Medicare will be secondary.

End-Stage Renal Disease: If you are eligible for Medicare as a result of End-Stage Renal Disease (permanent kidney failure), the plan will generally be primary and Medicare will be secondary for the first 30 months of your Medicare eligibility (regardless of the size of the employer). Thereafter, Medicare will be primary and the plan will be secondary.

If you have any questions about coordination of your coverage with Medicare, please contact PEEHIP for further information.

Medicare rules require a Medicare-eligible, active PEEHIP member who is covered on their spouse's PEEHIP **retired** contract to have Medicare as the primary payer on the active PEEHIP member. The active, Medicare-eligible member will need Medicare Part A and Part B coverage.

If the active member does not want Medicare as his or her primary payer and does not want to enroll in Medicare Part B until retirement, he or she will have to be insured on their own PEEHIP **active** contract and will not be able to combine allocations with the retired PEEHIP-eligible spouse. When the active Medicare-eligible member retires, he or she will need to enroll in Medicare Part B. The effective date of Medicare Part B needs to be the date of retirement to avoid a lapse in coverage.

## Retired Employees

Retired employees are not affected by the TEFRA amendment to the Age Discrimination in Employment Act; therefore, upon retirement and Medicare eligibility the member's coverage under PEEHIP will complement his/her Medicare coverage. Medicare will be the primary payer and the Public Education Employees' Health Insurance Plan will be the secondary payer for retires and dependents eligible for Medicare. Medicare approved admissions will not be subject to the Preadmission Certification requirements. The Public Education Employees' Health Insurance Plan remains primary for retirees until the retiree is Medicare-eligible. **A Medicare-eligible retiree and/or spouse must have both Medicare Part A & B to have adequate coverage with PEEHIP. In most cases, Medicare-eligible retirees and dependents should not enroll in the new Medicare Part D program.**

After Medicare pays 80% of the approved amount after the Part B deductible, the PEEHIP plan will pay the remainder of the Medicare approved amount without a Major Medical deductible (subject to a $20 copay on office visits, emergency room visits and outpatient consultations) on PEEHIP approved services. In rare situations some services are covered by Medicare and are not by PEEHIP. In the rare situation that a service is not covered by Medicare but is covered by PEEHIP, PEEHIP will be primary and all PEEHIP deductible and copayment amounts will apply as will all PEEHIP precertification requirements.

# CERTIFIED COMMUNITY MENTAL HEALTH CENTERS MAIN ADMINISTRATIVE OFFICES

In order for a member or eligible dependent to be eligible for covered benefits from any of the Approved Outpatient Facilities, Approved Inpatient/Residential Substance Abuse Facilities and Approved Psychiatric Facilities, the member or eligible dependent must be precertified and referred from one of the Certified Mental Health Centers listed on the following pages.

| | **Service Area** |
|---|---|
| **Baldwin County Mental Health Center, Inc.* ****<br>372 South Greeno Road<br>Fairhope, Alabama 36532-1905<br>1-800-738-2871 (access to care) | Baldwin |
| **Brewer – Porch Children's Center**<br>P.O. Box 870156<br>Tuscaloosa, Alabama 35212<br>(205) 348-7236 | Tuscaloosa |
| **Cahaba Center for Mental Health-Mental Retardation****<br>417 Medical Center Parkway<br>Selma, Alabama 36701<br>(334) 875-2100 | Dallas<br>Perry<br>Wilcox |
| **Calhoun-Cleburne Mental Health Center****<br>331 East 8th Street<br>P.O. Box 2205<br>Anniston, Alabama 36202<br>(256) 236-3403 | Calhoun<br>Cleburne |
| **Cheaha Mental Health Center****<br>P.O. Box 1248<br>351 West Third Street<br>Sylacauga, Alabama 35150<br>(256) 245-2201 | Clay<br>Coosa<br>Randolph<br>Talladega |
| **Cherokee-Etowah-DeKalb Mental Health Center****<br>901 Goodyear Avenue<br>Gadsden, Alabama 35903<br>(256) 492-7800 | Cherokee<br>DeKalb<br>Etowah |
| **Chilton-Shelby Mental Health Center****<br>P.O. Drawer 689<br>Calera, Alabama 35040<br>(205) 663-1252 | Chilton<br>Shelby |
| **East Alabama Mental Health Center* ****<br>2506 Lambert Drive<br>Opelika, Alabama 36801<br>(334) 742-2877 or 1-800-815-0630 | Chambers<br>Russell<br>Tallapoosa<br>Lee |
| **East Central Mental Health-Mental Retardation Board****<br>200 Cherry Street<br>Troy, Alabama 36081<br>(334) 566-6022 | Bullock<br>Macon<br>Pike |

**Eastside Mental Health Center**
129 East Park Circle
Birmingham, Alabama 35235
(205) 836-7283

Jefferson
Blount
St. Clair

**Gateway Family Counseling Office**
1401 South 20th Street
Birmingham, Alabama 35205
(205) 510-2761

Jefferson
Blount
St. Clair
Walker

**Gateway Family Counseling Office**
333 Business Circle
Pelham, Alabama 35124
(205) 510-2780

Shelby

**Glenwood Mental Health Services**
150 Glenwood Lane
Birmingham, Alabama 35242
(205) 969-2880

All
Alabama
Counties

**Indian Rivers Mental Health Center****
3701 Loop Road East
VA Medical Center
P.O. Box 2190
Tuscaloosa, Alabama 35403
(205) 562-3700

Bibb
Pickens
Tuscaloosa

**Jefferson-Blount-St. Clair MH-MR Authority**
940 Montclair Road, Suite 200
Birmingham, Alabama 35213
(205) 595-4555

Jefferson

**Mental Health Center of Madison County* ****
4040 South Memorial Parkway
Huntsville, Alabama 35802
(256) 705-6366

Madison

**Mental Health Center of North Central Alabama**
4110 Highway 31 South
Decatur, Alabama 35603
(256) 355-6091 or 1-800-365-6008 (access number)

Lawrence
Limestone
Morgan

**Mental Healthcare of Cullman****
P. O. Box 2186
Cullman, Alabama 35056
(256) 734-4688

Cullman

**Mobile Mental Health Center* ****
2400 Gordon Smith Drive
Mobile, Alabama 36617
(251) 450-2211

Mobile
Washington

**Montgomery Area Mental Health Center**
101 Coliseum Boulevard
Montgomery, Alabama 36109
(334) 279-7830

Autauga
Elmore
Lowndes
Montgomery

**Mountain Lakes Behavioral Healthcare****
2409 Homer Clayton Drive
Guntersville, Alabama 35976
(256) 582-3203 or 1-800-209-0049

Jackson
Marshall

| | |
|---|---|
| **Northwest Alabama Mental Health Center****<br>1100 7th Avenue<br>Jasper, Alabama 35501<br>(205) 302-9000 or (205) 302-9017 | Fayette<br>Lamar<br>Marion<br>Walker<br>Winston |
| **RiverbendCenter for Mental Health* ****<br>635 West College Street<br>P.O. Box 941<br>Florence, Alabama 35631<br>(256) 764-3431 | Colbert<br>Franklin<br>Lauderdale |
| **SouthCentral Alabama Mental Health Center****<br>P.O. Box 1028<br>Andalusia, Alabama 36420<br>1-877-530-0002 (access number) | Butler<br>Coffee<br>Covington<br>Crenshaw |
| **Southwest AlabamaMental Health – Mental Retardation Center****<br>P.O. Box 964<br>Monroeville, Alabama 36461<br>(251) 575-4203 | Clarke<br>Conecuh<br>Escambia<br>Monroe |
| **UAB Community Psychiatry****<br>4th Floor<br>908 20th Street South<br>Birmingham, Alabama 35233<br>(205) 934-7008 (access number) | Jefferson |
| **West Alabama Mental Health Center****<br>1215 So. Walnut Avenue<br>Demopolis, Alabama 36732<br>1-800-239-2901 | Choctaw<br>Greene<br>Hale<br>Marengo<br>Sumter |
| **Wiregrass Mental Health System****<br>**(Spectra Care)**<br>134 Prevatt Road<br>Dothan, Alabama 36301<br>(334) 794-0731 | Barbour<br>Dale<br>Geneva<br>Henry<br>Houston |

* Also approved for day hospitalization

** Also approved for intensive outpatient program treatment